County Borough of Smethwick

The

Health of the Borough

in

1949

HUGH PAUL, M.D., D.P.H.
Medical Officer of Health,
Tuberculosis Officer and
School Medical Officer.

JOHN H. WRIGHT, M.B.E., F.S.I.A.
Chief Sanitary Inspector.

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County Borough of Smethwick.

COMMITTEES—1949-1950

Health Committee:

Chairman: Alderman Mrs. E. M. Farley, J.P.

Vice-Chairman: Alderman W. H. Perry.

The Mayor (Ald. C. G. Spragg, O.B.E., J.P.).
Alderman A. Bradford, J.P.
Alderman F. W. Perry, J.P.
Councillor E. T. Brown.
Councillor H. Hamilton, M.R.C.S., L.R.C.P.
Councillor W. G. Mason.

Co-opted Members for the purpose of Maternity and Child Welfare:

Mrs. W. C. Dugmore, Miss S. C. Wright.

Mental Health Sub-Committee:

All members of Health Committee.
Miss L. N. Brook.

Welfare Sub-Committee;

Chairman: Councillor E. T. Brown.

Alderman A. Bradford, J.P.
Alderman Mrs. E. M. Farley, J.P.
Alderman F. W. Perry, J.P.
Alderman W. H. Perry.

The Hollies and Day Nurseries Sub-Committee:

Chairman: Alderman Mrs. E. M. Farley, J.P.

The Mayor (Ald. C. G. Spragg, O.B.E., J.P.).
Alderman F. W. Perry, J.P.
Alderman W. H. Perry.
Councillor E. T. Brown.

Health and Education Joint Sub-Committee:

Representing Health Committee.

Alderman Mrs. E. M. Farley, J.P.
Alderman F. W. Perry, J.P.
Alderman W. H. Perry.

Representing Education Committee.

Alderman C. H. Marriott, J.P.
Mr. H. O. Hughes, M.A., B.Sc.
Councillor Mrs. M. Kimberley.

Health and Housing Joint Sub-Committee :

Representing Health Committee.

Alderman A. Bradford, J.P.
Alderman W. H. Perry.
Alderman Mrs. E. M. Farley, J.P.

Representing Housing Committee.

The Mayor (Ald. C. G. Spragg, O.B.E., J.P.).
Councillor E. T. Brown.
Alderman Mrs. E. Lee.

HEALTH DEPARTMENT STAFF.

Medical Officer of Health, Tuberculosis Officer and School Medical Officer:
Hugh Paul, M.D., B.Ch., B.A.O., D.P.H.

Senior Assistant Medical Officer of Health:
H. Tabbush, M.B., Ch.B., D.P.H.

Assistant Medical Officers:
Margaret E. McLaren, M.B., Ch.B., D.P.H.
Christina J. McLeay, M.B., Ch.B.

Chief Sanitary Inspector: (*de*): John H. Wright, M.B.E.

Deputy Chief Sanitary Inspector: (*def*) R. G. Evans.

Sanitary Inspectors:

(*def*) G. J. Allen.
(*deg*) J. H. Morris.
(*de*) J. W. M. Rivers (to 28.2.49).
(*d*) R. G. Marshall (from 10.3.49).
(*de*) T. H. Cutler (to 24.2.49).
(*d*) L. G. Francis.
(*de*) E. F. Kelly.
(*dg*) N. W. E. Cox (from 21.3.49).
(*dg*) A. E. Siggers (from 1.4.49).

Pupil Sanitary Inspector: R. G. Marshall (to 9.3.49).

Secretary: (*d*) George H. Roe.

Clerical Staff:

(*h*) J. B. Chaplin, Chief Clerk.
T. Ryder, Senior Clerk.
Frances K. Callard (i/c M.C.W.).
Florence E. Howlett (i/c S.M.S.).
Evelyn M. Smith (M.O.H.'s Secretary).
Lilian Parish.
A. J. Ward.
Mary L. Whitehouse.
Barbara R. Edgington.
Winifred Batsford.
Jane M. G. Donoghue.
J. E. Beddall.
Jean Hall (from 21.3.49).
F. A. Collett (from 10.10.49).
G. A. Capes (from 1.3.49 to 31.8.49).
Kathleen L. Whiston.
M. H. Critchley.
Mrs. I. Palmer (to 17.3.49).
Cynthia J. Lane.
T. A. Grosvenor (H.M.F. 10.5.49).
T. P. Jones.
Anne Aston (from 8.8.49).

Telephonist and Receptionist:
Evelyn M. Haffey (to 11.6.49).
Mrs. J. Wotherspoon (from 13.6.49).

Duly Authorised Officer: (*i*) W. A. Harnden.

Nursing Staff:

Superintendent Health Visitor: (*abc*) Miss E. Williams.

Health Visitors:

(*abc*) Miss H. Owen.
(*abc*) Miss J. E. Ackers.
(*abc*) Miss J. High.
(*abc*) Miss M. Wainwright.
(*abc*) Miss M. Jose (from 6.9.49).
(*abc*) Miss M. P. O'Keeffe.
(*abc*) Miss E. A. Roberts.
(*abc*) Mrs. D. Grainger.
(*abc*) Mrs. M. Taylor (formerly Lavin).

Student Health Visitors:

(*ab*) Miss M. E. Curran (from 16.9.49).
(*ab*) Miss M. Adams (from 2.5.49).
(*ab*) Miss F. Hughes (from 30.5.49).
(*ab*) Miss D. Hunt (from 2.5.49).
(*ab*) Miss W. Kenny (from 24.4.49)
(*b*) Miss G. May (from 31.5.49).

Clinic Nurses:

(*ab*) Mrs. B. E. Smith.
(*ab*) Miss G. E. Clarke.
Mrs. H. M. Warner.
(*ab*) Mrs. W. M. Cave.

The work of these Health Visitors and Nurses is divided between the Health and Education Committees.

Municipal Midwives:

Nurse A. Grosvenor.
Nurse L. Jacques.
Nurse W. Kenny (to 23.4.49).
Nurse N. O. Scrivens.
Nurse B. Ewings.
Nurse L. Chatwin.
Nurse M. A. King.
Nurse D. Maybury (from 10.1.49).
Nurse M. S. Fletcher (from 28.3.49).
Nurse I. Banner (from 4.7.49).

Home Nurses:

(*b*) Miss H. M. Davis.
(*b*) Mrs. M. A. Worrall.
Mrs. E. B. Weaver.

Home Nurses (Part-time):

(*a*) Mrs. E. G. Winnett.
(*aj*) Mrs. S. F. Hutchinson.

Chiropodists:

(*k*) Miss A. M. Dobson.
(*k*) J. Beaumont.

Matron of "The Hollies": (*ab*) Miss A M. Robinson.

Matrons of Day Nurseries:

Norman Road	(*bl*)	Mrs. M. Barrass.
Brasshouse Lane		Miss I. M. Clarke.
Edgbaston Road		Miss M. E. Griffin.

Ambulance Officer: A. F. Beacon.

Assistant Ambulance Officer: C. R. Twycross.

Public Analyst: F. C. D. Chalmers, M.A., B.Sc., F.I.C.

a State Certified Midwife.
b State Registered Nurse.
c Health Visitor's Certificate.
d Sanitary Inspector's Certificate of the R.S.I. and S.I.E. Joint Board.
e Meat and Food Inspector's Certificate of the R.S.I.
f Smoke Inspector's Certificate of the R.S.I.
g Certificate in Sanitary Science.
h Diploma in Public Administration.
i Certificate of the Poor Law Examination Board.
j Registered Sick Children's Nurse.
k Member of the Chiropody Society.
l Registered Fever Nurse.

County Borough of Smethwick

PUBLIC HEALTH DEPARTMENT,
"THE UPLANDS,"
HALES LANE,
SMETHWICK,
September, 1950.

To the Mayor, Aldermen and Councillors for the County Borough of Smethwick.

Mr. Mayor, Ladies and Gentlemen,

At the moment of writing two years have passed since the National Health Service Act of 1946 came into operation. The general pattern of its administration is beginning to show, at least in outline, and experience so far has demonstrated clearly that the structure of the Act is sound and well designed to provide for community care. The medical service is, in general, adequate in quantity and quality to meet the needs of the community.

The actual fabrication of this huge structure of legislation was however so speedily conceived and rushed into operation that inevitably defects in detail began to show themselves at an early date. The building is sound but the plumbing and electrical installation already show signs of requiring overhaul.

The main advantages of the National Health Service Act are obvious and evident and are very great. The disadvantages are equally apparent, and it is desirable that in the implementation of this Act, attention should be paid more to the defects than to the good points. The latter may be left to take care of themselves; the former require careful study.

The main defect in the administration of the Act is that the three vertical systems of control, the hospitals, the general practitioners, and the local health authorities, are tending to become more and more isolated, and the diaphanous curtain which from the beginning separated the three groups is turning from a light textile to a heavy wool, and from a heavy wool to almost an iron curtain. This almost complete separation of the three structures of medical care is unfortunate, and may well become disastrous. It exists, not because of any lack of goodwill between those persons engaged in the operation of the Act in all three spheres, but because the natural tendency of officers carrying out a job is to work in harmony with their team mates—yet in isolation from those persons whom they do not know, and in whom they are not interested.

Let us now consider these three systems of control separately.

THE HOSPITALS

What is the function of the hospital? Ninety-nine persons out of a hundred would say that it is to cure the patients sent to it, but it will scarcely be disputed that such a conception is narrow and insufficient and out of touch with modern ideas of progress. The hospital is a unit in the health services, and unless it is integrated into the health scheme in such a way that it fully plays its part it is not functioning in the way it should.

Hospital experts tell us that for an efficient hospital service we require an increase in beds in the nature of 40% above the present accommodation. I suggest this is the wrong method of approach and that the main function of the hospital service should be to see in what way the number of beds could be *reduced*.

Let us assume that a specialist officer of a Regional Board proposes a scheme for the treatment of his speciality, say neurosurgery. The first questions which will be asked by the Board are: What is the extent of the demand for this service and what is the most economic way in which these demands may be met? This approach is wrong. The first question to be asked should be: In what way can these demands be met *without* the provision of hospital beds? How can the number of patients suffering from neuro-surgical conditions be reduced? In other words, the emphasis should be on the reduction of the demand rather than the supply of beds to meet it. This approach makes the problem much more difficult. It is far easier, if much more expensive, to treat existing patients than to carry out investigations into the cause of the illnesses and the means at our disposal of preventing them.

Let us take an example from industry. Supposing the Board of Management of a large motor manufacturing firm were to find that an increasing proportion of their cars were returned to the Service Department for carburetter repairs. What would be their reaction? If they followed the example of the Hospital Management Committees their task would be simple; they would arrange for increased floor space, increased buildings and increased equipment in the Service Repair department adequate in quantity and quality to deal promptly and efficiently with the incoming complaints. This, however, is hardly the line of approach which a modern manufacturer would adopt if he wished to keep out of the bankruptcy court. He would at all costs endeavour to find out the *cause* of the defects in his carburetters and to remedy it at its source.

But supposing he had insufficient staff or insufficient financial resources both to deal with the incoming repairs and the investigations into the cause of the defects. Which would he sacrifice? The question needs only to be asked to be answered. Why then do Hospital Management Committees not consider it their duty to study this problem? The answer is that, firstly they are not particularly interested in problems which they have never studied, and which they have never regarded as within their competence, and secondly, with one exception, no Regional Hospital Board in this country has amongst its members a professional epidemiologist. The amazing situation exists that on fourteen Boards there is only one expert in the *prevention* of disease.

It is true, of course, that many if not most Hospital Authorities will claim that it is not the duty of the hospital to prevent disease, that this is the duty of the general practitioner and the local authority. Such a contention is a controversial one, but even if it were accepted there surely should be some over-riding and co-ordinating authority which will take an interest in the combined health services as a whole, and will ensure that an undue proportion of experts is not allocated to the Service Repair Department of the nation's man power.

It is suggested that 17,647 consultant medical officers in the hospital and specialist services are too many to allocate to mere cure.

One of the difficulties in the way of a broad-minded approach to these problems lies in the character of the Regional Boards themselves. The Boards are comprised in the main of three groups: local authority members, successful business men who have made good in industry and have been on the boards of voluntary hospitals in the past, and technical officers, most of whom are medical specialists. The business men serve on the Board under conditions of great difficulties. They are accustomed to judge of the relative importance of different factors in their own business by the criterion of finance—the measure is good if it brings in increased profits; it is bad if its adoption tends to ruin them financially. This conception is simple and appeals to those even of limited intelligence. The business man on the Hospital Board, however, finds his measurement of values has gone. The hospital is not run for profit, and he has no other values to take the place of the financial ones. Unlike the local authority member, he is not an expert in social values, and consequently can only interpret hospital efficiency in terms of the cost and size of equipment, the extent of the chromium and marble, and the appearance of the buildings. If the hospital has a larger X-ray or a larger pathological department, or spends more on the kitchen equipment than another hospital, he is apt to assume that his hospital is better run than the others. This unfortunately does not follow. The most important factor in a hospital is the standard of human care, and the business man finds difficulty in assessing this factor. In his own trade he keeps a careful watch on the finished product, but astonishing to say, when he goes on to a Hospital Board he frequently, and indeed, usually has little to do with the finished product, that is the discharged patient. Indeed, it is not uncommon to find even Chairmen of Hospital Management Committees who from one month to another never speak to or chat with the patients under their care. Such Chairmen are unfit for their job and should be removed.

The technical specialist on the other hand, if one may judge from the correspondence column of the medical press, is not interested in "administration." He rather looks down on what he contemptuously calls the planners, and frequently believes in what the business community would call "*laisser faire.*" He is apt, therefore, to take a highly individualistic approach to his work, and usually finds committees tedious and time-consuming.

The local authority representative is usually a man or woman who for many years has been accustomed to deal almost entirely in social values. His outlook is not confined to financial profit and loss, and his previous experience has led him to make such abstract comparisons as that between, for example, a new picture in an art gallery and the redecoration of the law courts, or a new boiler at the sewage farm. In other words, he is trained to contrast the social values of the expenditure of money in matters where the only standards of values are social, and from this it would appear that the ideal Board is one composed mainly, if not entirely, of members from major local authorities, advised by technical specialists, whose function is confined to advice and who have no vote.

Let us now consider the problems arising out of the separation of the hospital from the local authority and the general practitioner. It has always been the greatest defect of the hospital system that the patient has been regarded more as a pathological condition than a human being. He has commenced to exist on admission to the hospital and has ceased to exist when he has left. While he is in the hospital the tendency has always been to treat not the patient but his illness. It is difficult to suggest means by which this can be completely overcome, and much of the responsibility must lie with those responsible for the training of students in the medical schools. It may be a truism to say that a patient cannot be separated from his complaint, and that while it is easy to cure illnesses it is difficult to cure persons, but the average doctor has always been trained to think in terms of deviation from health rather than in terms of health itself. The patient enters the hospital where he meets complete strangers. He is subjected to physical, physiological, radiographic and bio-chemical tests, and is questioned closely about the organ, or organs, which are considered to be diseased, but it is uncommon for any of the medical staff to take an interest in the patient himself apart from his complaint. As one eminent surgeon has said: " Anyone can cure gastric ulcer but few can cure patients with gastric ulcer."

Increasing use is being made in the hospital of almoners, and now that hospital treatment is free these keen and enthusiast women are enabled to devote more of their time to the social problems of the patients, but their main efforts are directed rather to the disposal of the patient than to an examination of the problems which have given rise to the patient's medical condition, and which have caused the deviation from health. It is their duty, and one which within the limits set by their small numbers they carry out with skill and tact, to get in touch with the public health departments of the local health authorities and to supply them with certain information relative to the after-care of patients who are discharged. They are, however, in communication with persons whom they have never met, and whose abilities to provide the necessary after-care is, to them, an unknown quantity. They are unfamiliar, to a considerable extent, with the services which the local authority can give, and once the patient leaves the hospital, he usually leaves it for good, and therefore can be of no further interest to the social worker in the institution. The hospital almoner might, it is true, follow up " her case " by visiting the home, but her training is not of the kind which would fit her to do this, and the task is one which the health visitor is better trained to carry out. The man in the street, or more correctly, the woman in the home, already embarrassed as she is by domestic cares, rationing, etc., has to cope with a more varied selection of social visitors than is necessary; she may feel that the health visitor, the school nurse, the tuberculosis visitor, the mental welfare officer, the school attendance officer, the psychiatric social worker, the children's officer, the probation officer, the district nurse, the home help, the housing welfare officer, and many others, no doubt are important cogs in the social machine, and do a great amount of good, but the harassed housewife might well be forgiven if she suggested that many of their functions might well be entrusted to one " general purposes " visitor to whom she could tell all her social problems, and who would be interested in all her children, and in all her difficulties.

The remedy would appear to be that the social work of the hospital should be carried out by the health visitors of the local authority. This would be both more convenient to the patient and more logical than sending the almoner into the district. The health visitor has a wide and varied experience of domestic problems and of problems connected with occupation, and well understands the relationship between health and the social environment. This practical training is not possessed by the almoner. Again, the hospital is not a social unit, particularly if it is a large one. Its patients may come, and frequently do come, from a wide area, and in the wards they are unknown to one another. Their stay, except in the case of the chronic patients, is relatively brief, and there is no opportunity for the development of a community spirit, even if such a community spirit could do much to help them. The health visitor, on the other hand, is in social charge of an area in her town which is a community unit. and in which she mixes. She knows the local problems and the local people. If it were part of her routine duties to visit the patients from her own district when they are sent to hospital, and get into direct and early contact with the medical and nursing staff of the ward to which the patient has been committed, she could in many cases give to the hospital officers in charge of treatment a valuable picture of the patient's background, such as would enable them to visualise the patient as a human being and not as a case. In some cases the social information which she would give might be of little value, but in a large proportion of cases the social background is far more important than the patient's signs and symptoms, and an understanding of this background will enable the medical and nursing staff to cure the patient, where otherwise they would be restricted to the treatment of the disordered organ.

This suggestion is not one which will appeal greatly to the staffs of either the local health authority or the hospitals. It is not administratively " tidy," and would call for much day-to-day improvisation. But the greatest criticism the public has to make of the public services is that they are apt to be designed to suit the convenience of the Authority rather than to serve the needs of the public. It is better to have continuous crises in the administrative machine than to have them amongst the public which it serves.

THE PROBLEM OF STAFF.

Since the 5th July, 1945, the Regional Hospital Boards have been making strenuous efforts to increase the recruitment of domestic and nursing staff to the hospitals. The local authority has also endeavoured to recruit more women in order to carry out their heavily increased duties under Part III of the Act, to say nothing of their welfare work under Part III of the National Assistance Act. The Minster of Education finds that the country is very short of teachers, and a continuous campaign goes on to attract suitable women into the teaching profession.

It does not, however, appear to have occurred to anybody to consider the effect of the low birth rate in the early thirties on the available pool of female labour. The Registrar General estimates that in 1938 the number of girls of eighteen years of age was 400,000, and in 1948 it was 297,000, a reduction of over 25%. There is no reason to believe that figures for the other age groups round about eighteen differ much from the above. We therefore have a pool of female labour of the age groups suitable for professional recruitment which has been reduced greatly in size in the brief period of ten years.

Out of this pool frantic endeavours have been made to recruit more nurses, more teachers, more domestic science teachers, more radiographers, more physiotherapists, more dietitians, more catering officers, more chiropodists, more dental mechanics, more dispensers, more mental health workers, more psychiatric social workers, more laboratory technicians, more occupational therapists, more speech therapists, more orthoptists, more almoners, more shorthand-typists, more doctors, more pharmacists, more physicists, more bio-chemists, more remedial gymnasts, and indeed more of every professional class of women. All this from 25% fewer women! Between 1946 and 1951, according to an estimate of the Minister of Labour, the number of women aged fifteen to forty in the population will have fallen by 374,000.

Nursing is an attractive career and always has been, and during the past few years, particularly since the end of the war, has attracted into its ranks far more than before the war. The numbers entering the profession and the numbers completing their training are steadily going up, and the policy of the Hospital Boards calls for an annual recruitment of 15,000 trained nurses. Should the hospitals extend their services and their numbers of beds, still further increases in the number of nurses required will be unavoidable.

There is a shortage of midwives, and the midwifery section of the Ministry of Health is making frantic efforts to attract more midwives into the profession. The Minister of Education is very dissatisfied and wants an annual recruitment of 11,000 women teachers. The teachers' organisations complain bitterly that it is impossible to provide proper education for classes of about forty children and are pressing for smaller classes. Everyone is shouting for typists, there is a chronic shortage of radiographers, speech therapists are almost impossible to obtain, dental and medical receptionists are required in increasing numbers.

In addition the Minister of Labour has the idea that the export drive could do with some more women workers.

The above figures show that the present state of affairs is fantastic and bears no relation to reality. The organisation which tries to increase its nursing staff is really asking the question—how can we *prevent* women becoming teachers, typists, etc.? The Minister of Education in his quest is asking a similar question—How can we prevent women becoming nurses? Dentists are asking—How can we prevent women becoming nurses or teachers; and business firms, local authorities and hospitals alike are doing their best to prevent women of suitable calibre from becoming teachers, nurses, dental attendants, radiographers—anything but shorthand-typists!

A government spokesman (Lord Shepherd, Lord-in-Waiting, House of Lords, 9th Nov., 1948) quoted in " The Times " of the 8th November, 1948, stated that the number of nurses in the country had increased from 152,000 in 1938 to 180,000 in 1948. During this decade, therefore, the total number of nurses increased by no fewer than 28,000, while the total number of girls of eighteen declined from 400,000 to 297,000. The CMO of the Ministry of Health in his Report for 1948 gives some illuminating figures. The number of student nurses increased during the calendar year 1948 by 3,906, that is from 41,394 to 45,300, and he alludes to this as a "considerable improvement." As many of these girls might have become teachers one wonders what the comment of the Minister of

Education would be. As many of them might have taken positions in industry one wonders what the comment of the Minister of Labour would be.

The Chief Medical Officer in the report referred to above shows that there were approximately 400,000 hospital beds in occupation in 1948, and he gives details of the number of staff looking after these patients. They include 8,800 whole-time doctors and 21,150 doctors working part-time, a total of over 30,000. Of these no fewer than 17,647 are specialist staff. In addition to the doctors the hospitals employed 15,080 other technical officers whole-time and 2,003 part-time. The administrative and clerical staff amounted to no fewer than 43,736. To look after these the various Regional Hospital Boards employed at their Staff Headquarters a further 2,123 persons. Adding the 150,000 nurses employed it will be seen that approximately 220,000 whole-time workers of all types and about 48,000 part-time look after these 400,000 patients; but this is not the whole story. The above figures do not include the domestic staff, and it is probable that the number of persons occupied in looking after the patients amounts to approximately one member of the staff to one patient.

In domiciliary medical practice a little over 20,000 doctors undertake the care of the sick public in their own homes, and their average lists are therefore about 2,200 persons per doctor. This average does not show the true state of affairs as many doctors living in such outlying districts as the isles surrounding this country and the interior of Devon and Cornwall have very small lists, and the average doctor in an industrial area looks after about 3,000 persons.

There are about 200 medical officers of health employed by local health authorities, and though figures are not available probably about 2,000 doctors are employed altogether in the preventive services.

The figures given call for careful thought. The relative numbers *may* be correct, but so far it has been nobody's business to enquire if in fact they *are* correct. Is it right that there should be one doctor in the hospital and specialist services for every thirteen or fourteen patients and one general practitioner for 2,200 panel patients? Is one doctor per 20,000 of the population the correct proportion of the country's medical man power to be allocated to the prevention of disease? At the moment nearly 40,000 doctors are helping to cure the sick, about 2,000 to keep them from being ill. Is this proportion right? Does anyone know? Is it right to keep on taking from the reduced pool of adolescent girls commencing their training for their life work more and more for the hospitals, more and more for the schools, and more and more for administrative positions in local authority? Is it desirable to lower the standards of education, culture and intelligence in order to skim off a higher proportion from this pool of woman power? Indeed, these questons are unanswerable. The desirability or otherwise should not arise because the possibility does not exist of making this vast increase. Scientists tell us with monotonous repetition that one cannot get a quart out of a pint pot, and neither idealism, public spirit, love of the job, increased pay, extensive advertising campaigns, improved conditions of service, canteens and other amenities will succeed in obtaining more than 297,000 workers from 297,000 persons. This is simple arithmetic, and I make no apology for rubbing it in.

The remedy? The time has obviously come when some authoritative body should investigate the relative claims on the available pool of man power for the medical services, indeed, for the utilisation of all the professional services, and its primary task should be to find out what proportions are desirable for each branch of service. Do we need more hospital nurses, and if so, is the need for hospital nurses more clamant than the need for more teachers? What proportion of nurses should be engaged in hospitals in the *cure* of patients, how many nurses should be working in the homes on the districts, at the clinics trying to *prevent* people taking ill? Is it right to employ 17,647 consultant medical officers in the hospitals and specialist services while 20,000 doctors are engaged in practice? Is the prevention of disease so unimportant that only 2,000 can be spared out of over 40,000 for this work?

THE ISOLATION HOSPITAL.

That part of the National Health Service Act which causes the greatest anxiety to those interested in the prevention of disease is that which handed over the isolation hospitals to bodies who have no experience in their administration and, worse still, no conception of their purpose. To the clinician the fever hospital is a place where patients go in and are given clinical treatment. To the medical officer of health the isolation hospital is an integral part of his equipment for the prevention of disease, and treatment is entirely secondary. He considers that the possession of a Diploma in Public Health is infinitely of more value to the worker in the isolation hospital than the possession of a higher clinical qualification, and views with alarm the present tendency to divorce treatment from prevention and to exclude from the hospital, except as a visitor, the epidemiologist, whose task it is to prevent outbreaks of disease and to control them when they occur. It is undoubtedly true that the clinicians taking over these curative functions will learn in time the true values of the fever hospital, but at the cost of the patient. There is little doubt that eventually the isolation hospitals in their present or some other form will revert to the local authority and come under the control of the local authority's epidemiologist. To quote a trade slogan, " Eventually, why not now?"

LOCAL AUTHORITY.

The local authority has had removed from its jurisdiction the care of the hospitals and the tuberculosis services but has had added to it a number of important duties. These new duties are mainly concerned with the social care of certain persons in the community who require special care in their own homes. The National Assistance Act has enlarged these responsibilities to include institutional provision for the aged and infirm.

The care of the chronic sick is divided by an artificial and rather arbitrary line between the Regional Hospital Boards and the Local Health Authorities. The dividing line is the need for medical care in an institution. In actual practice this dividing line is almost impossible to define, and a substantial proportion of the chronic sick in the community vary in their physical condition from month to month, at one period needing hospital treatment and at another period requiring only domestic and nursing care.

Prior to the 5th July, 1948, a local authority officer had the power to send a patient requiring medical care into a municipal hospital whether or not the latter was willing to accept him. These arbitrary powers were on the whole exercised with tact and judgment and seldom, if ever, gave rise to any practical difficulties. Up to the 5th July, 1948, therefore, it was always possible to get a chronic patient into hospital.

These powers have now gone, and the situation during the past two years has so rapidly deteriorated that it would be well nigh impossible to reimpose them. Chronic patients are rarely popular in a hospital, and as soon as the hospital authorities obtained relief from these social obligations waiting lists of chronic patients grew in number. Quite naturally the medical officers of institutions were not only willing but eager to give priority to patients needing immediate treatment at the expense of those who could wait. The number of admissions of acute patients to hospitals, therefore, increased substantially, but the chronic sick, paticularly those who were incurable, have been left to their own devices.

On the other hand, recent surveys have shown that a very substantial proportion of the inmates of chronic hospitals do not require institutional treatment and should never have been admitted. They were admitted originally because their home conditions were unsatisfactory, and they were unable to receive the necessary care and attention in their own homes which alone would have sufficed for their needs. Thousands of these unfortunate chronic sick are still in hospital and cannot be discharged because they have no homes to go to, and it is probably true to suggest that if all the patients in the Regional Board Hospitals who do not require institutional treatment were discharged there would be ample accommodation for those chronic patients who are suffering in their own homes in misery for lack of this provision. It is easier to state the problem than to resolve it, but it calls for a high degree of co-operation between the local authority and the Regional Board, and this co-operation is most necessary at patient level rather than at committee level. It is the duty of the local authority to remove from the hospitals the patients who do not require institutional treatment, but most local authorities having been given this obligation only on the 5th July, 1948, have not yet been able to make the necessary provision for these persons. A number of homes for the aged have, it is true, been opened, and their number is increasing, but this is not the full solution. Many of these patients should go not to a Home for the aged, however well run and however attractive, but to a home of their own, and the problem in many cases is solely one of housing.

Even when the provision of housing alone is not sufficient a number of these hospital residents will best be cared for by being discharged to a simple type of bungalow or flat, with the assurance that the local authority will provide them, where necessary, with domestic help free of cost or at charges which they could well afford. The local authority should also provide them with free home nursing.

It cannot be too strongly emphasised that the care of the majority of these persons in their own homes, or in small local authority Homes, is far more economic than their upkeep in hospital. The cost of hospital treatment is very heavy amounting often, even in chronic hospitals, to £7, £8 and £10 per week. The average annual cost per occupied bed in hospital, obtained by dividing the total cost of the hospital and specialist services by the number of occupied beds is estimated for 1949-50 as no less than £595.

The cost of caring for these persons in their own homes amounts only to a fairly small sum in money to maintain them, the cost of a domestic help, usually part-time, and the cost of visits from the district nurse. These three items, the financial assistance, the domestic help and the nurse together represent much less than the hospital cost. Even in Homes for the aged and infirm where no medical treatment is necessary the cost is usually about £3 per week. It will be seen, therefore, that the expansion of schemes by local authorities for the care of these persons in their own homes is an economy, but beyond this the happiness of the person concerned is infinitely greater. It is unfortunately true that when an aged and infirm person is taken to hospital merely because of infirmity or because of some chronic illness he, or more frequently she, feels that she has received a life sentence from which there is no reprieve. There is no reduction of 25% in the sentence for good conduct; liberty has gone, and however attractive the institution there is a sense of loss of freedom.

The policy of dealing with these people on the lines indiciated above calls for a high degree of public spirit on the part of the local authority. These persons when sent into hospital involve no charge on the local authority, the total cost being borne by the Regional Board. When the local authority, however, provide the home services, the cost of housing and the provision of domestic help and nursing fall on the rates, and the total sum to a progressive authority will undoubtedly be a substantial and increasing burden. Their only reward will be the obvious increased happiness of the persons served.

THE MEDICAL PRACTITIONER.

The general medical practitioner working for the Local Executive Council may call upon the health visitors, the home nurses, and domestic helps of the local authority, but in actual practice he is often too busy. The social problems of his patients are left to the local authority and the health visitor, and therefore he works more or less in isolation. The co-operation however, between the general practitioner and the local authority is very much closer than that between the local authority and the hospital, and it is probably true to say that the general practitioner and the local authority officer work closely together for the good of their patients, and extensive use is made by the practitioner of the facilities offered by the health department staff.

The relationship between the general practitioner and the hospital are somewhat confused, and both recent legislation and organisation inside the hospital are combining to making it more and more difficult for the practitioner to send his patient to the hospital doctor for *immediate* diagnosis and help. The number of days interposed between all except emergency patients and their treatment, is rapidly and steadily increasing. Appointments three weeks ahead are usual—appointments three months ahead are not uncommon, and treatment of chronic complaints often take very many months. The general practitioner is scarcely encouraged to visit his patient in hospital, although when he does visit, he is received with every courtesy. Many of his patients, however, are sent to hospital not for hospital treatment, but for investigation for which only the hospital has facilities, and it is unfortunate that many of these facilities are only available to the practitioner through a senior member of the hospital staff; for example, the general practitioner may find great difficulty in getting the result of an examination of the patient's blood, a bacteriological examination, or a radiograph, except by making an appointment with the appropriate consultant in the hospital. This may be excellent hospital etiquette, but it is deplorable medical practice, and the technical facilities of the hospital, particularly those associated with bacteriology and biochemistry should be immediately available to the general practitioner without the intervention of a third person except when the general practitioner asks for an opinion, as well as for a test. The consultant naturally fears that if bacteriological and biochemical examinations are transmitted to the general practitioner without a skilled interpretation, more harm than good may ensue, but the general practitioner is no fool, and it is part of his training to interpret these results, and if he is doubtful about the interpretation he can easily discuss the matter over the 'phone, in the absence of his patient, with any bacteriologist, or any biochemist on a completely impersonal level.

From the public health point of view, the removal of the general hospitals to the Regional Boards has been a god-send. As stated in a previous report, it has enabled the medical officer of health and his staff to free themselves from the tedious routine of hospital administration and to devote their time to the sociological and epidemiological problems which are their particular province. There are, however, one or two aspects in which the transfer has been singularly unfortunate, and the most important of these relate to the transfer of infectious disease hospitals and of the tuberculosis service to the Regional Hospital Board.

TUBERCULOSIS

The problem of the prevention of tuberculosis is outstandingly the most important task confronting the medical profession in this country, and it is important to understand both the magnitude of the task and the results so far achieved. Since the beginning of the century the reduction in the death rate from this disease has been spectacular, and in 1949 the death rate was less than 40% of the rate at the beginning of the century.

Nevertheless, at the present time ~~[illegible]~~ 400 persons die every week in this country from tuberculosis. It is true that nearly three and a half times as many persons die of cancer, but cancer is a disease of advancing years. Tuberculosis is more largely a disease of adolescence and early manhood and womanhood, and the amount of invalidity and disruption of the country's economy is far greater in the case of tuberculosis than in the case of cancer. The table below, which was quoted by Dr. Tattersall of Reading in " The Lancet " a few months ago, shows this clearly:—

TABLE 1.

Deaths in 1946 among selected age groups from six common causes. The percentage of deaths within the sex-age group due to each cause is shown in parenthesis.

	Age (years) and sex					
Causes	20 — 24		40 —44		60 — 64	
of Death	M	F	M	F	M	F
Tuberculosis ...	905	1542	1256	618	1111	336
	(34%)	(55%)	(18%)	(12%)	(4%)	(2%)
Cancer ...	120	67	1156	1508	5396	5109
	(4·5%)	(2·4%)	(17%)	(29%)	(21%)	(27%)
Cerebral Hæmorrhage	11	11	160	218	1686	2119
	(0·4%)	(0·4%)	(2·3%)	(4·2%)	(6.5%)	(11%)
Heart Diseases ...	165	197	1004	744	7074	4754
	(6.3%)	(7%)	(15%)	(14%)	(27%)	(25%)
Respiratory Diseases ...	132	143	705	393	3949	1609
	(5%)	(5%)	(10%)	(7·5%)	(15%)	(8.4%)
Violence ...	677	138	815	277	930	435
	(26%)	(5%)	(12%)	(5·3%)	(3·6%)	(2·3%)
All Causes ...	2645	2832	6799	5271	25740	19120

These figures are staggering. More than half the deaths of women and more than a third of the deaths of men between 20 and 25 are due to tuberculosis, and these deaths occur not in the twilight of life but at the dawn of working life when the value to the community of the lost lives is at its greatest. These deaths are preventable.

Tuberculosis, therefore, is by far the most important illness amongst the working section of the community, and as such, exacts a heavier toll on our public economy than any other. As a comparison it may be of value to quote one or two figures. The disease, anterior-poliomyelitis, in the largest epidemic which this country ever experienced (1947), killed 707 persons, while diphtheria killed 244 and scarlet fever 42. In the same year tuberculosis killed 23,550. These deaths, to the extent of 400 each week, cannot and must not be ignored. They cannot be materially reduced by the clinical application of any known curative measures, and wonderful though streptomycin and P.A.S. may be, it is doubtful if throughout the entire country they can produce as many cures or as much alleviation of suffering as resulted from the improvement in social conditions which followed the removal of wartime restraints and restrictions.

THE NEW CONTROL

The trend of administrative procedure in the control of tuberculosis is causing a considerable amount of disquiet in Public Health circles, and under the present administrative set-up it would appear difficult to continue the scheme which has been such a brilliant success during the past half century.

It might be well before going further to give in very broad outline the history of the control of tuberculosis in this country. The schemes in operation before the 1946 Act were founded basically on the conception that the tuberculosis problem was a social one rather than a medical one, and that the prevention of the disease was more important than its cure. All the work in connection with the campaign was centred round the tuberculosis dispensary or Chest Clinic; the tuberculosis officer was a member of the staff of the local Health Authority, and his basic training was that of a doctor trained in preventive medicine, with a specialised knowledge of clinical tuberculosis. He was expected to possess, and almost invariably did possess, the Diploma in Public Health, and usually for a period before he became a tuberculosis officer had undertaken general public health duties. He was thus soaked in the spirit of preventive medicine, and was accustomed to regard health, and not the cure of disease, as his ultimate aim and object.

A tuberculous patient to him represented a failure of society to protect him. His immediate object, apart from the treatment of his patient, was to put into operation all possible measures for the prevention of the spread of the disease. The examination of the family contacts was therefore no minor procedure to be left to a junior, but a major task which called for the exercise of his highest skill. The Mantoux testing, the radiograph and the bacteriological examination of contacts were important and impressive parts of his work, but beyond this his own personal visits to the home played no unimportant part in the prevention of the disease, and his social efforts, perhaps consciously, perhaps unconsciously, did more to prevent the disease than all his clinical work. For example, he realised that housing is far more important than the provision of hospital beds, and that a decent standard of living contributed more to the problem than pneumothorax, and that gold in the pocket of the patient was of more value than gold injected into his system. This point may appear academic but it is of vast importance. Tuberculosis incidence is rising although the death rate is falling, and this is mainly due to the fact that so many tuberculous patients are living in crowded conditions, often in single rooms, often in slums, often with their parents-in-law, often with no possibility of isolating themselves from other susceptible members of the household, including not only their own relatives but other unrelated occupants of the house. This problem can only be partly solved by a large increase in hospital beds, because the hospital is not a penal establishment and the patient cannot be retained indefinitely. The need for more beds is indeed admitted, and is clamant, but the need for better housing is far more important.

The present tuberculosis officer is deeply aware of this, and until 1948 his close association with the local authority enabled him to use personal influence with the Council's Housing Committee to secure a share of the new houses for his patients. He was an officer of the local authority in close touch with his fellow officials, and strongly supported by his own department, the Public Health Department; and the combination of the tuberculosis officer, the medical officer of health and the housing manager, was usually effective in obtaining for his patients more than their fair share of houses. It is to be hoped that this close co-operation will continue in future, but it is obvious that the influence on the Housing Committee of a stranger, such as the new tuberculosis officer will eventually be, is bound to be less productive than that of a fellow official enjoying intimate relations with officials of other departments.

The training of the new tuberculosis officer has been widely discussed, and at least one important memorandum has been issued by an authoritative committee of Scottish specialists in tuberculosis. It is alarming to note their conception of the new tuberculosis officer. After receiving his medical training at a University the tuberculosis aspirant goes through his usual years of hospital service, including general hospitals and hospitals specialising in the treatment of tuberculosis. He has to proceed to the rank of Registrar, and in the course of his hospital career will obtain the medical qualification of M.R.C.P. He is not expected to obtain the Diploma in Public Health, although the committee consider that a three months' course of training (the C.P.H.) would be an advantage. The committee consider that he need not be responsible in any way to the local authority, and should be a whole-time employee of the Regional Hospital Board. After leaving hospital he would receive tuition in all branches of tuberculosis work at the tuberculosis dispensary.

This policy is catastrophic. It means that the whole conception of the work of a tuberculosis officer is centred round the Hospital with its rigid and narrow curative outlook. The M.R.C.P. is almost entirely a qualification in the cure of disease, is narrow in its conception, and is of little use to a missionary whose call is to prevent disease. How unlike his old colleague, who was steeped to his bone marrow in ideas and ideals of prevention. It may be claimed that he may be taught preventive methods in and around the Chest Clinic, but experience of other branches of clinical medicine show only too clearly that the glamour of cure is intoxicating, and at any rate in other branches of medicine has always taken precedence over the work of prevention.

The remedy for this state of affairs is fairly clear. The tuberculosis service should be handed back to the local authorities, not perhaps in its old form but modified in the light of recent experience. The part-time tuberculosis officer climbing the ladder to an administrative position is obsolete, and no attempt should be made to resuscitate him, but the tuberculosis officer should pass through a considerable apprenticeship in a Public Health Department before being allowed to do tuberculosis work. He should be part of the team of the local authority, and his motto should be prevention. He should be removed as far as possible from the narrow and cramping influence of the curative exponent of his profession, and should live in an atmosphere of prevention.

Arguments against this course are well-known and unconvincing. The graduate who has his M.R.C.P. may be better able to *treat* tuberculosis than his colleague who has " wasted " a year or two in preventive medicine, but it cannot be too strongly stressed that the tuberculosis problem is not one of cure but of prevention. The cure of a tuberculous patient is at the best an unstable one; the disease can be rendered quiescent by skilled treatment, but the physician in his clinical work has contributed to a pathetically small extent to the solution of the problem. A tuberculous patient treated by the most modern and approved methods still has a second class life, and is always liable to relapse. A person, who because of the activities of an exponent of preventive medicine has *not* contracted tuberculosis, may live a life of perfect health and usefulness for his natural span.

PREVENTION OR CURE.

In the field of health and medicine the greatest danger this country has to face is the possibility, and perhaps the probability, that the glamour of curative medicine in a community with restricted man power, and of restricted means, may jeopardise or halt the campaign of prevention, which alone can build up a healthy community. That prevention is better than cure is universally acknowledged, but the truth goes no farther than the lips, for it is an unfortunate fact that the average member of the community will pay all he possesses in order to be cured in some medical or surgical emergency, but will grudge or be indifferent to expenditure of a much smaller sum in preventing the onset of his illness.

The outlook of the man in the street on health and disease is entirely emotional, and only rarely is reason exercised in its appreciation. To illustrate this more fully we may take an actual example. Two children are born in a street to different parents in different homes; one child is healthy and unblemished, the other is a " blue baby." Is it more important to endeavour to cure the blue baby of a deficiency which otherwise will kill him or to prevent the first child contracting tuberculosis? The answer which will be given is, that it depends on who is making the decision. The parents of the blue baby will naturally vote for the money being spent on the operation which has recently been carried out by a number of eminent surgeons. The parents of the healthy child will vote for the money being spent on the prevention of tuberculosis, but, stop—Is this true?

The answer is, that it is *not* true. Both the parents of the blue baby *and the parents of the healthy child* will vote for the money being spent on the blue baby. Let there be no confusion on this point. The parents of the healthy child have no problem;

the possibility of tuberculosis is not before their eyes, the plight of the blue baby is. They will, therefore, not consider it a sacrifice in any way on their part if they vote for a cure of the blue baby. Let us pursue this problem more closely. The blue baby operation is a recent one. It consists of surgical interference with the baby's blood vessels of such a nature that, after a successful operation the baby has a much more adequate supply of pure oxygenated blood passing to his tissues. He is not cured but his life is prolonged. He is likely to live for many more weeks, or months, or years, but from the point of view of the community he will probably always be a passenger and not a worker. It is more than doubtful if in the most successful cases he will ever repay the country for the money spent on him in the first fifteen years of his life. The cost of the blue baby operation is probably about £60, and at the end of it, if the operation is successful we still have an invalid. The healthy baby, however, if he is prevented from contracting tuberculosis, other things being equal, will live a normal life for the average allotted span. No one is grateful for what does not happen, and few people are willing to pay for the prevention of catastrophies which they are confident will never visit *them* or *their* children.

The problem cannot be pigeon-holed; a decision must be made —the blue baby or the healthy child needing to be protected against tuberculosis. The average person in this country runs a one in twenty chance of dying of tuberculosis, and a doctor, therefore, who succeeds in putting into operation measures to protect twenty healthy children from tuberculosis will have saved one life. How many lives are saved by the doctor who sits in the clinic and immunises 120 children against diphtheria? How many lives did the Medical Officer of Health of G——— and his assistants save by their action in dealing with the outbreak of smallpox which occurred a few months ago in their city? The answer to these questions cannot be given with accuracy, but at least, in the case of a smallpox outbreak one does know that absence of action on the part of the medical staff would have resulted in more deaths in a single month than could be saved by the entire hospital services of the entire country over a considerable period of time, and it must be stressed that the man who is prevented from getting smallpox by administrative action does not suffer pain or incarceration, whereas the hospital patient to be cured must be admitted to an institution and must suffer the pain and inconvenience of his illness.

An elderly patient suffering from cancer in one of the hospitals of a Regional Hospital Board (not Birmingham) was prescribed by the consulting surgeon a course of medical treatment involving the use of a drug of very high expense. The cost of this drug over a period of three months, I was told, would have been equal to the entire drug bill of the hospital for the corresponding period, and the hospital was confronted with the choice, its budget being limited, of reducing expense elsewhere or depriving this patient of treatment which would have eased the condition but would not have cured the patient.

Should this drug have been given? The answer is emphatically no.

Before a refusal to supply this drug is described as inhuman and unsympathetic let us consider what the implication of a decision such as this really means. The Minister of Health has decided on a total sum of money for the hospital services which must not be be exceeded, and although there may be some difference of opinion as to what the amount available for the health services should be, there can be no dispute about the fact that the expenditure on the health services *must* have a definite limit controllable by the Exchequer. Any other course would, from the point of view of national economy, be ridiculous. Whatever this sum, however, it will be insufficient to provide for *all* the demands made by those operating the new services in the hospitals, in the homes, in the clinics, in the laboratories, on immunisation schemes, etc. Sooner or later, therefore, the question of priorities will have to be decided. Health is purchasable, and in the present state of the national economy the community can only purchase a certain amount of health.

Tuberculosis could, for example, be much more rapidly reduced by the expenditure of a very considerable sum of money; this is obvious when one realises that tuberculosis is twice as common amongst the lowest paid workers than the highest social class. We therefore come back again to the question as to whether a large and substantial sum should be paid for the purchase of a drug which will give relief but not cure to a patient in the last few months of life, or to devote the money to some other aspect of health, such as the prevention of tuberculosis.

The Hospital Management Committee which makes the decision as to whether or not to supply an expensive drug are actuated partly by financial influences but mainly by considerations of sympathy and sentiment. This sympathy, however, would soon be recognised as rank sentimentality if it became necessary in order to obtain the money deliberately to go out into the highways and by-ways and give to a child an attack of tuberculosis which would maim it for the rest of its life! This example may appear ridiculous but it is, in fact, the type of decision which is being made. The decision is usually in favour of the patient who is present and seen, at the expense of that nebulous person the absent child, whose existence is not even noticed until he falls a victim to a preventable disease.

It will scarcely be denied that looking at the matter coldly, it is a business proposition to keep the people healthy rather than to allow them to become ill and then endeavour to cure them by the spectacular activity of a glamorous profession. The delights, the pleasures, and the temptations of clinical work appeal to the average doctor when he has qualified, and it will be a matter of great difficulty to persuade him to take up a career where the spiritual satisfactions are so nebulous and where immediate success is not so visible. The satisfaction of a doctor who has carried out a difficult operation or has cured an acutely ill patient in a few days is very real, but the pleasure which a doctor receives from immunising 100 children against diphtheria is not evident to the doctor, and will never bring gratitude from a parent. The latter, however, is contributing more to the community than the former. How this attitude of glamour can be broken down is a matter of great importance, but it is unfortunate that in the recent set-up the clinicians have attracted to themselves prestige greater than other members of the profession in inverse proportion to their contribution to the common good.

The estimated costs of the National Health Service for 1949-50 were as follows:—

Hospitals and Specialists ...	£238,100,000
Family Doctors	47,100,000
Chemists, Dentists, Oculists, etc.	109,100,000
Miscellaneous	13,300,000
	407,600,0000
Local Authority Services (including Prevention)	31,400,000
	439,000,000

Seven per cent for prevention!

The total cost is colossal. The public pays the piper. What about the tune?

In conclusion I would like to thank the Chairman and Members of the Health Committee for their unfailing encouragement and help, my own staff, and my colleagues in other departments, for their willing assistance. The work entailed by the bringing into operation of the mass of new legislation has been almost overwhelming since the 5th July, 1948, but many of the arrears are being overtaken, and the schemes to which we are committed have been steadily brought into fuller operation. In spite of the shortage of staff, the officers of the Health Department have worked extremely hard and with unbounded enthusiasm under the greatest possible difficulties, and such successes as we may claim are due in no small part to their devoted and unselfish help.

I am, Mr. Mayor, Ladies and Gentlemen,

Your obedient servant,

HUGH PAUL, M.D., D.P.H.,

Medical Officer of Health.

Annual Report for 1949

GENERAL STATISTICS.

Area: 2,500 acres.
Population: Census, 1931—84,406.
Estimated pre-war: 78,290.
Estimated civilian population 1949: 77,430.
Rateable Value: April, 1949: £438,755.
Estimated Product of a Penny Rate: £1,720.
Rates in the £: 17/-d.
Estimated Number of Houses in the Borough: 21,743.

EXTRACTS FROM VITAL STATISTICS.

		1948	1949
Births:	Males	752	696
	Females	699	633
	Total	1,451	1,329
	Illegitimate Births included in above total	54	66
	Birth-rate per 1,000 population ...	18.8	17.1
Deaths:	Males	451	492
	Females	396	484
	Total	847	976
	Death-rate per 1,000 population ...	10.98	12.6
Infant Deaths:	Males...	29	26
	Females	13	29
	Total	42	55
Infant Mortality:	Legitimate	29.3	37.2
	Illegitimate	18.5	121.2
		28.9	41.3
	Deaths of Infants under 4 weeks	27	28
	Neo-Natal Mortality ...	18.6	21.0

DEATHS FROM:	No.	1948 Rate per 1,000 population	No.	1949 Rate per 1,000 population
Enteric Fever	—	—	—	—
Measles	1	0.01	1	0.01
Whooping Cough	—	—	2	0.02
Diarrhœa & Enteritis (under 2 years)	1	0.01	8	0.13
Diphtheria	—	—	—	—
Scarlet Fever	—	—	—	—
Influenza	2	0.02	20	0.25
Cancer	157	2.03	160	2.06
Respiratory Diseases	102	1.32	129	1.66
Pulmonary Tuberculosis	48	0.62	45	0.58
Other Forms of Tuberculosis	—	—	5	0.06
Cerebro-Spinal Fever	—	—	—	—
Acute Poliomyelitis	2	0.02	—	—
Acute Infective Encephalitis	1	0.01	1	0.01
Road Traffic Accidents	6	0.07	2	0.02
Suicide	8	0.10	7	0.09
Other violent causes	9	0.11	15	0.19

BIRTH-RATES, CIVILIAN DEATH-RATES, ANALYSIS OF MORTALITY, MATERNAL MORTALITY AND CASE-RATES FOR CERTAIN INFECTIOUS DISEASES IN THE YEAR 1949

	Smethwick	England and Wales	126 County Boro's and Great Towns including London	148 Smaller Towns (Resident Population 25,000 to 50,000 at 1931 Census)	London Administrative County
	Rates per 1.000 civilian population				
BIRTHS:					
Live Births	17.1	16.7 (a)	18.7	18.0	18.5
Still Births	0.37	0.39 (a)	0.47	0.40	0.37
DEATHS:					
All Causes	12.6	11.7 (a)	12.5	11.6	12.2
Typhoid and Paratyphoid ...	—	0.00	0.00	0.00	0.00
Whooping Cough...	0.02	0.01	0.02	0.01	0.01
Diphtheria	—	0.00	0.00	0.00	0.00
Tuberculosis ...	0.64	0.45	0.52	0.42	0.52
Influenza	0.25	0.15	0.15	0.14	0.11
Smallpox	—	0.00	0.00	—	—
Acute Poliomyelitis and Polioencephalitis	0.01	0.01	0.02	0.02	0.01
Pneumonia	0.59	0.51	0.56	0.49	0.59
NOTIFICATIONS (Corrected):					
Typhoid Fever ...	—	0.01	0.01	0.01	0.01
Paratyphoid Fever	—	0.01	0.02	0.01	0.01
Cerebro-spinal Fever	0.01	0.02	0.03	0.02	0.02
Scarlet Fever	1.45	1.63	1.72	1.83	1.46
Whooping Cough...	2.86	2.39	2.44	2.39	1.70
Diphtheria	0.15	0.04	0.05	0.04	0.07
Erysipelas	0.16	0.19	0.20	0.19	0.17
Smallpox	—	0.00	0.00	0.00	0.00
Measles	13.03	8.95	8.91	9.18	8.54
Pneumonia	1.12	0.80	0.91	0.65	0.55
Acute Poliomyelitis	0.01	0.13	0.13	0.12	0.18
Acute Poliencephalitis	0.01	0.01	0.01	0.02	0.01
Food poisoning ...	0.06	0.14	0.16	0.14	0.19
	Rates per 1,000 Live Births :—				
DEATHS:					
All causes under 1 year of age... ...	41	32 (b)	37	30	29
Enteritis and Diarrhœa under 2 years of age ...	6.0	3.0	3.8	2.4	1.7
	Rates per 1,000 Total (Live and Still) Births :—				
NOTIFICATIONS (Corrected):					
Puerperal Fever and Pyrexia ...	2.20	6.31	8.14	5.30	6.32

MATERNAL MORTALITY

	Rates per 1,000. Total (Live and Still) Births		Rates per million women aged 15-44
	Smethwick	England & Wales	England & Wales
140 Abortion with Sepsis	—	0.11	8
141 Abortion without Sepsis	—	0.05	4
147 Puerperal Infections	—	0.11	
142-146, 148-150 other Maternal Causes ...	—	0.71	

(a) Rates per 1,000 total population. (b) Per 1,000 related births.

REVIEW OF VITAL STATISTICS IN SMETHWICK DURING THE PAST 25 YEARS.

Death rate per 1,000

Year	Birth rate per 1,000	Death rate per 1,000	Infant mortality rate per 1,000 births	Zymotic death rate	Respiratory diseases	Pulmonary Tuberculosis	Non-Pulmonary Tuberculosis	Cancer
1925	18.36	10.36	80.11	0.52	1.91	0.77	0.24	1.10
1926	18.35	10.39	65.86	0.37	1.88	0.79	0.10	1.26
1927	17.0	11.9	78.6	0.61	2.26	0.84	0.05	1.19
1928	17.1	10.0	63.0	0.28	1.52	0.69	0.10	1.11
1929	17.8	13.4	79.8	0.70	2.58	0.95	0.12	1.23
1930	18.0	10.4	66.4	0.41	1.17	0.67	0.11	1.28
1931	18.0	11.2	69.6	0.57	1.63	0.62	0.10	1.24
1932	15.2	10.5	78.4	0.23	1.36	0.52	0.09	1.53
1933	14.4	10.8	62.0	0.16	1.60	0.62	0.05	1.44
1934	15.7	10.6	56.9	0.22	1.60	0.57	0.14	1.20
1935	14.7	11.1	60.9	0.31	1.10	0.59	0.06	1.56
1936	15.5	10.5	59.9	0.18	1.60	0.54	0.02	1.47
1937	14.6	11.5	52.5	0.27	1.64	0.70	0.02	1.35
1938	15.3	11.0	62.2	0.25	1.28	0.70	0.10	1.59
1939	14.8	10.7	54.5	0.26	1.04	0.52	0.05	1.79
1940	15.3	14.0	41.9	0.14	2.72	0.61	0.07	1.86
1941	15.09	13.9	60.0	0.18	2.10	0.84	0.06	1.89
1942	17.2	12.0	54.5	0.16	1.81	0.70	0.08	1.92
1943	18.6	13.08	64.5	0.24	2.03	0.84	0.05	2.15
1944	20.6	12.2	45.0	0.26	1.14	0.80	0.07	2.05
1945	18.6	12.8	50.4	0.08	1.53	0.79	0.08	1.99
1946	20.09	12.28	50.1	0.18	1.62	0.73	0.05	1.94
1947	21.2	11.7	42.9	0.11	1.33	0.67	0.13	1.75
1948	18.8	10.98	28.9	0.02	1.32	0.62	—	2.03
1949	17.1	12.6	41.3	0.14	1.66	0.58	0.06	2.06

INCIDENCE OF INFECTIOUS DISEASE.

SCARLET FEVER.

The incidence of, and mortality from, scarlet fever during the past five years is as follows:—

Year	Cases Notified	Attack rate per 1.000 population	Number of deaths	Case mortality per cent.
1945 …………	100	1.39	—	—
1946 …………	148	1.98	—	—
1947 …………	89	1.17	—	—
1948 …………	119	1.54	—	—
1949 …………	113	1.46	—	—

DIPHTHERIA.

The incidence of, and mortality from, diphtheria during the past five years is as follows:—

Year	Cases Notified	Attack rate per 1.000 population	Number of deaths	Case mortality per cent.
1945 …………	42	0.58	5	11.9
1946 …………	33	0.44	2	6.06
1947 …………	13	0.17	—	—
1948 …………	4	0.05	—	—
1949 …………	12	0.15	—	—

The number of children immunised during the past four years is as follows:—

	1946	1947	1948	1949
Under five years of age ……	1,090	895	1,132	1,029
From five to fifteen years …	813	1,013	808	939
Totals ……	1,903	1,908	1,940	1,968

In addition, 718 children received reinforcing injections during 1949.

At the 31st December, 1949, it was estimated that 3,564 of the child population under five, and 13,953 children from five to fifteen were protected against diphtheria.

TYPHOID AND PARATYPHOID FEVER.

No notifications of typhoid or paratyphoid fever were received during the year.

CEREBRO-SPINAL FEVER.

One case of cerebro-spinal fever was notified: the patient recovered. During 1948 two cases were notified and both recovered.

WHOOPING COUGH AND MEASLES.

There was a substantial reduction in the number of cases of whooping cough notified during the year, the attack-rate being 2.86 per 1,000 of the population, compared with 2.39 in the whole country. There were two fatal cases. The notifications of measles showed a further rise, with an attack-rate of 13.03 per 1,000, compared with 8.95 per 1,000 for England and Wales. There was one death.

	Cases Notified			Attack-rate		
	1949	1948	1947	1949	1948	1947
Whooping Cough	222	436	263	2.86	5.65	3.47
Measles	1,009	873	768	13.03	11.32	10.15

FOOD POISONING.

Five notifications were received during the course of the year, but except that two cases occurred in one family there was no connection. In one case shell-fish appeared to be implicated; in none of the others was it possible to trace the source of infection. In one case the sanitary conditions of the house were very unsatisfactory, food was left uncovered, flies were present in large numbers, and the w.c. (shared with the next house) was frequently blocked as the result of improper use by children. In no case was any suspected food available for examination. Each of the patients made a rapid recovery.

NOTIFIABLE DISEASES (OTHER THAN TUBERCULOSIS) DURING THE YEAR 1949

Disease	TOTAL CASES NOTIFIED										Cases removed to hospital	TOTAL DEATHS						
	Age Groups											Age Groups						
	All ages	0-1	1-3	3-5	5-10	10-15	15-25	25-45	45-65	65 and over		All ages	0-1	1-5	5-15	15-45	45-65	65 and over
Smallpox	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Enteric or Typhoid Fever ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Paratyphoid Fever	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Scarlet Fever	113	...	11	36	49	11	4	2	...	...	9	...	...	...	...	...	...	...
Diphtheria	12	...	1	4	1	...	2	2	2	...	9	...	...	...	...	...	...	...
Erysipelas	13	...	1	...	...	...	3	3	5	1	...	...	...	...	...	...	...	...
Puerperal Pyrexia	3	...	...	...	...	...	...	2	1	...	1	...	...	...	...	...	...	...
Ophthalmia Neonatorum ...	6	6	...	...	...	...	...	...	...	...	1	...	...	...	...	...	...	...
Cerebro-spinal Fever ...	1	...	...	...	...	...	...	...	1	...	...	...	...	...	...	...	...	...
Acute Polioencephalitis ...	1	...	...	...	...	...	...	...	1	...	...	...	...	...	...	...	...	...
Acute Poliomyelitis	1	...	...	...	1	...	...	...	...	...	1	...	...	...	...	...	...	...
Malaria...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Dysentery	22	2	7	4	3	1	...	3	2	...	...	...	...	...	...	...	...	...
Acute Pneumonia	86	4	7	5	6	2	9	11	19	23	3	46	11	2	...	3	3	27
Whooping Cough	222	21	70	77	51	2	...	1	...	...	5	2	1	1	...	...	...	...
Measles...	1,009	47	319	324	297	12	5	4	1	...	18	1	1	...	...	...	...	...
Food Poisoning	5	...	...	2	...	...	...	...	1	2	1	...	...	...	...	...	...	...
Totals	1,494	80	416	452	408	28	23	28	33	26	48	49	13	3	...	3	3	27

VACCINATION.

The Council's Scheme under Section 26 of the National Health Service Act, 1946, provides for the performance of vaccination by general practitioners taking part in the Authority's scheme, as well as for special sessions for infant vaccination to be held at Child Welfare Centres or other centres if found necessary.

Two hundred and eleven primary vaccinations were carried out by private practitioners, and at sixteen special sessions, 238 primary vaccinations were carried out by the Department's medical officers.

The following is a record of the vaccinations carried out during the year ended 31st December, 1949:—

	Primary Vaccinations	Re-vaccinations
Children under one year ...	406	—
Children aged 1—5 years ...	21	2
Children aged 5—15 years ...	9	2
Persons over 15 years of age	13	90
	449	94

For some little time after the "appointed day" the demand for vaccination was very small, but there are signs of the numbers increasing again. The position is very unsatisfactory, however, and steps are being taken to ensure that the advisability of vaccination is brought to the notice of the parents of newly-born children.

VENEREAL DISEASES.

Returns from the General Hospital, Birmingham, and (for 1949) from the treatment centre at Lancaster Street, Birmingham, show the number of Smethwick patients dealt with for the first time as under:

	1945	1946	1947	1948	1949
Syphilis	21	33	19	21	11
Gonorrhœa ...	30	42	26	38	26
Conditions other than Venereal ...	80	140	107	106	101
Totals	131	215	152	165	138

TUBERCULOSIS.

NOTIFICATIONS.

The following table shows the notifications received and the attack rate with the deaths and death-rate for each year since the commencement of the Public Health (Tuberculosis) Regulations, 1912:—

	Notifications received:		Attack Rate per 1,000 of the population:		Deaths		Death-rate	
	Pulmonary	Other forms	Pulmonary	Other forms	Pulmonary	Other forms	Pulmonary	Other forms
1913 ...	318	50	4.3	0.68	64	20	0.87	0.27
1914 ...	143	167	1.9	2.2	84	14	1.15	0.19
1915 ...	229	103	3.1	1.4	79	15	1.09	0.21
1916 ...	204	117	2.6	1.4	91	12	1.16	0.15
1917 ...	206	126	2.6	1.6	103	6	1.31	0.07
1918 ...	194	80	2.5	1.0	97	11	1.27	0.14
1919 ...	260	60	3.5	0.8	87	9	1.19	0.12
1920 ...	146	31	1.9	0.4	62	24	0.81	0.31
1921 ...	88	14	1.1	0.18	53	17	0.68	0.22
1922 ...	112	17	1.4	0.2	61	25	0.78	0.32
1923 ...	80	18	1.02	0.2	73	14	0.93	0.17
1924 ...	110	18	1.39	0.2	53	14	0.67	0.17
1925 ...	74	24	0.9	0.3	61	19	0.77	0.24
1926 ...	94	16	1.2	0.2	61	8	0.79	0.10
1927 ...	87	38	1.1	0.49	65	4	0.84	0.05
1928 ...	73	25	0.8	0.29	59	9	0.69	0.10
1929 ...	108	34	1.2	0.4	81	11	0.95	0.12
1930 ...	76	19	0.89	0.22	57	10	0.67	0.11
1931 ...	80	29	0.93	0.33	53	9	0.62	0.10
1932 ...	65	20	0.76	0.23	44	8	0.52	0.09
1933 ...	55	16	0.64	0.19	53	5	0.62	0.05
1934 ...	72	19	0.85	0.22	48	12	0.57	0.14
1935 ...	95	19	1.15	0.23	49	5	0.59	0.06
1936 ...	81	21	0.99	0.25	44	2	0.54	0.02
1937 ...	77	4	0.95	0.04	57	2	0.70	0.02
1938 ...	78	20	0.97	0.25	56	8	0.70	0.10
1939 ...	89	15	1.11	0.19	40	4	0.52	0.05
1940 ...	52	15	0.72	0.20	44	5	0.61	0.07
1941 ...	83	10	1.15	0.14	61	5	0.84	0.06
1942 ...	102	28	1.40	0.38	51	6	0.70	0.08
1943 ...	92	20	1.27	0.27	61	4	0.84	0.05
1944 ...	126	17	1.74	0.23	58	5	0.80	0.07
1945 ...	151	26	2.1	0.37	57	6	0.79	0.08
1946 ...	149	16	2.00	0.21	55	4	0.73	0.05
1947 ...	165	12	2.18	0.15	51	10	0.67	0.13
1948 ...	216	14	2.80	0.18	48	—	0.62	—
1949 ...	182	15	2.35	0.19	45	5	0.58	0.06

and also NEW CASES coming to the knowledge of the Medical Officer of Health from the death returns, transfers from other areas, etc.

AGE PERIODS.	1948				1949				1938			
	Pulmonary.		Other forms.		Pulmonary.		Other forms.		Pulmonary.		Other forms.	
	M	F	M	F	M	F	M	F	M	F	M	F
0 to 1	1	1	1	—	2	—	—	—	1	—	—	—
1 to 5	4	14	1	2	11	9	2	2	—	—	—	—
5 to 10	31	23	1	2	9	15	1	1	—	4	—	—
10 to 15	11	10	—	2	11	17	1	2	—	1	3	—
15 to 20	4	10	—	1	6	12	1	—	6	4	2	2
20 to 25	3	7	2	—	5	8	—	1	5	6	2	1
25 to 35	27	16	3	1	12	15	1	1	12	12	—	2
35 to 45	17	9	—	—	10	6	1	—	7	4	2	2
45 to 55	25	2	—	—	11	7	—	—	8	3	—	1
55 to 65	11	2	—	—	10	3	1	—	7	5	1	1
65 to 75	12	2	—	—	6	2	—	—	1	—	—	1
75 upwards	—	1	—	—	—	—	—	—	—	—	—	—
TOTALS	146	97	8	8	93	94	8	7	47	39	10	10

The discrepancy between the number of new cases and the number of notifications received is accounted for by cases transferred from other areas.

The deaths from tuberculosis during 1948 and 1949 are shown as follows:—

AGE PERIODS.	1949				1948			
	Pulmonary		Other forms		Pulmonary		Other forms	
	M.	F.	M.	F.	M.	F.	M.	F.
0 to 1	—	—	—	—	—	—	—	—
1 to 5	—	—	1	1	—	1	—	—
5 to 15	—	—	—	—	—	—	—	—
15 to 45	12	9	1	1	14	0	—	—
45 to 65	16	5	1	—	10	4	—	—
65 up	3	—	—	—	6	3	—	—
TOTALS ...	31	14	3	2	30	18	—	—

The number of cases remaining on the Dispensary Register on 31st December, 1949, was 1,013, viz.:—

Pulmonary—Males ...	345	Non-Pulmonary—Males ...	28
Females...	245	Females...	38
Children..	247	Children..	110
	837		176

Attendances at the Chest Clinic were as under:—

	1949	1948
First examinations	1,005	970
Re-examinations	2,648	3,101
Consultations	3,695	2,324
Mantoux Tests	318	239
Artificial-pneumothorax	1,016	1,295
Gold Treatment	6	52
Artificial light treatment ...	58	110
Total attendances ...	8,746	8,091

	1949	1948
Number of X-ray examinations ...	2,313	2,468
Visits to patients at Home:—		
(*a*) By Health Visitor	850	650
(*b*) By Clinical T.O.	198	208
Patients admitted to Sanatoria ...	105	125
Patients discharged from Sanatoria. .	94	120
Patients died in Sanatoria	17	20
Patients remaining in Sanatoria at end of year	39	45

TABLES SHEWING ADMISSIONS to, and DISCHARGES from, SANATORIA during the Year 1949.

NAME OF INSTITUTION	Number of Cases in Sanatorium on January 1st, 1949.				Number of Cases admitted during 1949.				Cases discharged or transferred to the Chest Clinic.				Number of Deaths			Number of Cases in Sanatorium on December 31st, 1949.			
	Males	Females	Children	Total	Males	Females	Children	Total	Males	Females	Children	Total	Males	Females	Children	Males	Females	Children	Total
Holly Lane Hospital	8	3	1	12	33	27	2	62	23	23	3	49	4	5	...	14	2	...	16
Romsley Hill Sanatorium ...	5	1	...	6	19	17	1	37	17	11	1	29	4	2	...	3	5	...	8
Crossley Sanatorium, Cheshire ...	6	5	...	11	...	3	...	3	1	4	...	5	1	...	...	4	4	...	8
Creaton Sanatorium, N'thampton	3	6	...	9	...	...	...	...	2	5	...	7	...	1	...	1	...	...	1
Royal Nat. Sanatorium, Ventnor..	1	...	...	1	...	...	...	...	1	...	...	1	...	...	...	...	...	...	...
The Woodlands, Northfield ...	...	1	2	3	...	...	...	...	...	...	2	2	...	...	...	...	1	...	1
The Forelands, Bromsgrove ...	...	...	3	3	...	...	...	...	...	...	...	...	...	...	...	...	...	3	3
Yardley Green Sanatorium ...	...	...	...	...	1	...	2	3	1	...	...	1	...	...	...	...	...	2	2
Totals	23	16	6	45	53	47	5	105	45	43	6	94	9	8	...	22	12	5	39

	Classificat on admiss to the Institutio	Condition at time of discharge.	* Under 3 months.			3–6 months.			6—12 months.			More than 12 months.			Totals.			Grand Totals.
			M	F.	Ch.	M.	F.	Ch.	M.	F.	Ch.	M.	F.	Ch	M.	F.	Ch.	
PULMONARY TUBERCULOSIS.	Class T.B. minus.	Quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Not quiescent	4	3	...	5	9	...	3	2	...	...	1	...	12	15	...	27
		Died in Institution ...	...	...	...	1	...	...	...	...	...	...	...	...	1	...	...	1
	Class T.B. plus. Group 1.	Quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Not quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	..	...
		Died in Institution ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
	Class T.B. plus. Group 2.	Quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Not quiescent	1	3	...	2	2	...	...	...	...	...	...	...	3	5	...	8
		Died in Institution ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
	Class T.B. plus. Group 3.	Quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Not quiescent	7	1	...	17	13	1	4	3	...	2	...	...	30	17	1	48
		Died in Institution ...	...	1	...	1	1	...	...	4	...	1	...	...	2	6	...	8
Totals (Pulmonary)			12	8	...	26	25	1	7	9	...	3	1	...	48	43	1	92
NON-PULMONARY TUBERCULOSIS	Bones and Joints.	Quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Not quiescent	...	...	...	...	...	...	...	...	2	...	...	...	...	...	2	2
		Died in Institution ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
	Abdominal	Quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Not quiescent	...	...	...	...	...	...	...	..	...	...	...	...	...	...	...	...
		Died in Institution ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
	Other Organs.	Quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Not quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Died in Institution ...	...	...	...	...	1	...	...	...	...	...	...	...	...	1	...	1
	Peripheral Glands	Quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Not quiescent	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
		Died in Institution ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Totals (Non-Pulmonary) ...			...	...	...	...	1	...	...	...	2	...	...	...	...	1	2	3

*NOTE.—Patients whose stay in Residential Institutions has not exceeded 28 days are not included in this table.

RETURN SHOWING THE WORK OF THE DISPENSARY during the Year 1949.

DIAGNOSIS.	PULMONARY.				NON-PULMONARY.				TOTAL.				Grand Total
	Adults		Children		Adults		Children		Adults		Children		
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
A. (1) Number of definite cases of Tuberculosis on the Dispensary Register at the beginning of the Year	330	236	84	83	30	41	57	49	360	277	141	132	910
(2) Transfers from Authorities of areas outside that of the Council or Board during the Year	4	4	...	...	...	...	...	...	4	4	...	...	8
(3) Lost sight of cases returned during the Year	...	...	...	...	...	...	...	...	...	...	...	...	...
B. Number of New Cases diagnosed as tuberculous during the Year													
(1) Class T.B. minus	40	25	38	49	...	...	...	...	40	25	38	49	152
(2) Class T.B. plus	33	25	1	1	...	...	...	...	33	25	1	1	60
(3) Non-pulmonary	...	...	...	...	5	5	4	3	5	5	4	3	17
C. Number of cases included in A. and B. written off the Dispensary Register during the Year as:—													
(1) Recovered	15	18	2	...	4	5	1	...	19	23	3	...	45
(2) Dead (all causes)	43	18	...	...	1	1	1	1	44	19	1	1	65
(3) Removed to other Areas	4	9	4	3	2	2	...	...	6	11	4	3	24
(4) For other reasons	...	...	...	..	...	...	...	...	...	...	...	...	...
D. Number of definite cases of Tuberculosis on the Dispensary Register at the end of the Year	345	245	117	130	28	38	59	51	373	283	176	181	1013

Dr. Russell has furnished the following report on the work of the Chest Clinic during 1949:—

During the year 1949, a large volume of work was carried out at the Chest Clinic by the same staff as in 1948, with the addition of an assistant clerk appointed in March. At the end of the year, the number of cases on the register had risen to 1,013, an increase of 11% over the 1948 figure of 910. It was possible to discharge 45 patients off the register as cured. The number of " cures " each year is steadily rising, and is some reward for the long period of eight to ten years required to see a patient from first diagnosis, through treatment and careful subsequent supervision, to final discharge. There were 64 deaths, a high figure and a legacy of the increased incidence during the War, but it should be noted that not so many young people are dying from tuberculosis. The disease is now occurring more frequently in older persons. Over 1,000 patients were examined for the first time, an increase, and an indication of the keen co-operation of the general practitioners in the borough.

In spite of the loss of some beds after 5.7.48, the waiting list for Sanatorium treatment is small. As soon as the diagnosis is made, a female patient can be sent immediately to Sanatorium, and a male patient has less than three months to wait. The 22 beds at Holly Lane Hospital, and the 17 beds at Romsley Hill Sanatorium, have been fully utilised and fortunately we still have five beds at Crossley Sanatorium. Patients requiring thoracic surgery, are now being treated at Yardley Green Hospital, Birmingham, after a waiting period of approximately four months. The new drugs Streptomycin and P.A.S. are being used with great benefit, but they have not replaced Sanatorium and older methods of treatment.

Through the agency of the Ministry of Labour, many patients in the recovery stage have taken rehabilitation and training courses for new occupations, at the Handsworth Centre. We still lack a " Sheltered Factory " and hostel accommodation for cases capable of some work, but remaining infectious to others.

Adequate housing remains an urgent problem, but during the year, quite a number of tuberculous families have been rehoused, with the considerate co-operation of the Housing Committee. The free milk scheme has again been used to the full, in order to build up the resistance of children in tuberculous families. This is a long term preventative measure and will pay big dividends in the future.

B.C.G. vaccination has not yet been employed in Smethwick. The Ministry of Health prescribe limiting conditions for its use. My own personal view is that it is of little value for contacts. The survey of child contacts in 1948 showed that less than 1% of such children would be suitable for B.C.G. In my opinion, it would be better for adolescents who have escaped infection. I would suggest that all children leaving school at ages 15 to 16 years should be tuberculin tested and that B.C.G. vaccination could be offered to those found to be susceptible. The skin test is simple and harmless and, in a child, of much more value than a Chest X-ray in determining infection with tuberculosis.

I would further suggest that skin testing of children entering school at age 5, should be routine. In those cases yielding a positive result, the adults in the family should be investigated at the Chest Clinic. For many years, I have been using this method in a limited way, and I am satisfied that it is the most efficient way of discovering unsuspected adult cases, and it is more direct and much cheaper than mass radiography.

I would like to express my sincere gratitude to Miss Sharpe, Miss Underhill and Miss Allibone, for their most willing and cheerful assistance in carrying through another busy year's work at the Chest Clinic.

A. W. RUSSELL,

Tuberculosis Officer.

INFANTILE MORTALITY DURING THE YEAR 1949.

CAUSE OF DEATH	0-1 week	1-2 weeks	2-3 weeks	3-4 weeks	Total under 4 weeks	1-2 m'ths	2-3 m'ths	3-4 m'ths	4-5 m'ths	5-6 m'ths	6-7 m'ths	7-8 m'ths	8-9 m'ths	9-10 m'ths	10-11 m'ths	11-12 m'ths	Total
Whooping Cough	...	...	...	...	...	...	...	1	...	...	...	...	...	...	...	...	1
Measles	...	...	...	...	...	...	...	...	...	...	1	...	...	...	...	...	1
Bronchitis	...	...	...	...	...	1	1	...	...	1	...	...	...	...	...	...	3
Broncho-pneumonia	...	1	...	...	1	2	6	1	...	...	...	...	...	...	...	...	10
Lobar Pneumonia	...	...	...	...	...	...	1	...	...	...	...	...	...	...	...	...	1
Diarrhœa and Enteritis ...	...	...	...	...	...	1	2	1	2	...	2	...	...	...	...	...	8
Other Digestive Diseases ...	1	...	...	...	1	...	...	...	...	...	...	...	...	...	...	...	1
Mongolism	...	...	...	...	...	...	...	...	...	...	...	...	1	...	...	...	1
Spina Bifida	...	2	...	...	2	...	2	...	...	...	...	...	...	...	...	...	4
Other Congenital Malformations	4	...	...	...	4	...	...	...	...	...	...	...	...	...	...	...	4
Premature Birth	13	...	...	...	13	...	...	...	...	...	...	...	...	...	...	...	13
Injury at Birth	1	...	...	...	1	...	...	...	...	...	...	...	...	...	...	...	1
Intracranial Hæmorrhage ...	1	...	...	...	1	...	...	...	...	...	...	...	...	...	...	...	1
Atelectasis	3	...	...	...	3	...	...	...	...	...	...	...	...	...	...	...	3
Icterus Neonatorum	2	...	...	...	2	...	...	...	...	...	...	...	...	...	...	...	2
Asphyxia	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	1
TOTALS :—	25	3	...	...	28	4	12	3	2	1	3	...	1	...	...	1	55

MOTHERS AND CHILDREN.

NOTIFICATION OF BIRTHS.

The number of births notified during the past five years under Section 203 of the Public Health Act, 1936, as adjusted by transferred notifications, was as follows:—

	1945	1946	1947	1948	1949
Live Births ...	1,293	1,489	1,605	1,465	1,327
Still Births ...	38	25	43	31	27
Totals ...	1,331	1,514	1,648	1,496	1,354

Comparison with the returns of the local Registrar shows that very few births escape notification.

ANTE-NATAL CLINICS.

Since the establishment of the first Ante-Natal Clinic in 1920, the total attendances have been as follows:—

1920	42	1935	5,169
1921	107	1936	5,044
1922	127	1937	5,201
1923	241	1938	6,226
1924	275	1939	6,739
1925	537	1940	6,336
1926	1,015	1941	7,221
1927	1,079	1942	8,526
1928	1,465	1943	8,988
1929	2,253	1944	10,093
1930	3,760	1945	7,452
1931	3,859	1946	9,755
1932	3,509	1947	10,766
1933	3,771	1948	11,599
1934	4,312	1949	8,935

During the year 1949, 1,224 individual women attended the clinic (900 for the first time), compared with 1,506 in 1948, 1,667 in 1947, 1,793 in 1946, and 1,455 in 1945.

POST-NATAL CLINIC.

Statistics for the past five years show:—

	1945	1946	1947	1948	1949
Individual patients attending	474	465	580	592	403
Percentage of notified births	35	30.7	35.2	39.5	29.3
Total attendances	1,255	1,498	1,078	1,416	746

MIDWIFERY AND MATERNITY SERVICES.

The Council employs nine municipal midwives, and these undertake all the domiciliary cases in the area. During the year they attended 531 cases, in 354 cases as midwives and in 177 cases as maternity nurses. Statistics for the past five years are as under:

	1945	1946	1947	1948	1949
Number of bookings ...	602	740	751	677	598
Ante-natal visits ...	3,596	4,068	3,379	4,089	3,973
Cases attended... ...	588	654	734	632	531
Nursing visits	12,959	14,351	15,782	14,990	12,738

The number of cases in which medical aid was summoned during 1944 was 240; in 1945, 155; in 1946, 184; in 1947, 184; in 1948, 163; and in 1949, 80.

All our midwives are qualified to administer gas and air analgesia; two sets of apparatus are available, and were used in 80 cases during the year. Seven additional sets of apparatus are on order.

Pupil midwives taking Part II training at St. Chad's Hospital are received on the district by four midwife-teachers on the staff of the Department for periods of three months domiciliary training. Fifteen such pupils were received during the year.

DENTAL TREATMENT.

Dental Service provided during the year ended 31st December, 1949.

(a) Numbers provided with Dental Care

Patient	Examined	Needing Treatment	Treated*	Made Dentally fit
Expectant and Nursing Mothers	778	601	257	170
Children under five	337	233	202	197

* Includes patients inspected in 1949, but not treated in that year.

(b) Forms of Dental Treatment provided

Patient	Extractions	Anæsthetics		Fillings	Scalings or Scalings & G.T.'s	Silver Nitrate Treatments	Dressings	X-Rays	Dentures	
		Local	General						Complete	Partial
Expectant & Nursing Mothers	648	4	140	285	92	2	9	—	21	12
Children under five	492	—	179	31	4	3	11	—	—	—

Mr. Littlefield has furnished the following report on the treatment of expectant and nursing mothers and young children during the year.

" I have pleasure in submitting my report on the dental services provided by the Authority under Section 22 of the National Health Service Act, 1946, for the year ended 31st December, 1949. As I reported last year, in November, 1948, a scheme was introduced whereby every expectant mother attending the Ante-Natal Clinics was inspected by a Dental Officer. This scheme has worked well during the year, the number inspected being 778 compared with 281 in 1948. The following table gives an analysis of these inspections :—

Inspected	Sound	Referred for Treatment	Private Practitioner	Refused Treatment	Appointment Not Kept
778	177	601	168	56	139

" Of the number referred for treatment, 377 consented to treatment at the Clinic, but 139 failed to keep their appointments. Only a small number subsequently asked for and received further appointments. A total of 33 dentures were supplied during the year, their construction again being in the hands of a dental technician to the profession.

" Inspection of children attending the Nursery School and Nursery Classes in Primary schools has been continued, but the figures relating to these inspections have not been included in Table (a). They have been included in the figures of school inspections in the report of the School Dental Service. This year, the three Day Nurseries have each been inspected twice and the following table analyses the results. The children inspected were aged from 2½—4 + years:—

Day Nursery	No. Inspected	No. Sound	No. Defective but not Referred	No. Referred	No. of Acceptances
Edgbaston Road 1st	34	18	4	12	5
2nd	28	16	1	11	4
Norman Road 1st	19	13	—	6	2
2nd	25	15	—	10	4
Brasshouse Lane 1st	35	26	2	7	7
2nd	37	20	10	7	5

" In addition children under 5 whether or not they are attending a Welfare Centre have attended as Casuals, have been examined and treated as required. It has not been possible to formulate any satisfactory scheme of periodical inspection of those children attending the Welfare Centres as their numbers are small in the 2—4 + age groups and their attendance irregular. The Medical and Nursing staffs of these Centres, do refer, however, any child whom they consider to be in need of dental treatment.

" The number of children examined (337 — Table (a)) includes the Day Nurseries and those who attended the Clinics as Casuals.

" Although not now the responsibility of the Authority, emergency dental treatment was given in a small number of cases for T.B. patients and mentally defective patients.

" An X-ray machine has been installed at the Cape Hill Clinic and will provide a valuable diagnostic aid in cases of obscure dental conditions.

" Out of 1,647 sessions worked by the Dental Officers, 177 were devoted to treatment under this section of the Act and the equivalent of .4 of a full-time officer was so employed.

" In conclusion, I wish to express my thanks to the Medical, Nursing and Clerical staffs of the Health Department for the assistance given to the dental service during the year."

GEO. J. S. LITTLEFIELD,

Senior Dental Officer.

INFANT WELFARE CENTRES.

The number of centres provided and maintained by the Council is seven, with ten sessions weekly; the total attendance during the past five years was:—

	Under 1 year	1—5 years	Total
1945	20,903	5,729	26,632
1946	20,804	5,097	25,901
1947	22,279	3,606	25,885
1948	21,755	3,326	25,081
1949	19,180	3,032	22,212

		1948	1947
Number of children attending for the first time	Under 1 year ...	1,199	1,082
	1—5 years ...	111	94
	Total ...	1,310	1,176
Number of children on the registers at end of year	Under 1 year ...	1,083	989
	1—5 years ...	1,970	1,600
	Total ...	3,053	2,589

The number of children under one year who attended for the first time equalled 83.2 per cent. in 1945, 83.3 per cent. in 1946, 82.7 per cent. in 1947, 81.8 per cent. in 1948, and 81.5 per cent. in 1949.

CARE OF PREMATURE INFANTS.

During the year 1949 notification was received of 85 babies who weighed 5½ lbs. or less at birth. Of these 30 were born at home, and 55 in hospital. Twenty-three of those born at home survived at the end of one month; five died during the first 24 hours. Of the babies born in hospital 43 survived at the end of one month; nine died during the first 24 hours.

Special provision is made for the conveyance of premature infants to hospital by the Borough Ambulance Service.

The follow-up of infants discharged from hospital is secured through the Obstetrics Officer in St. Chad's Hospital, who is also Medical Supervisor of Midwives, and who, as a member of the Public Health Department Staff, is also in close touch with the Health Visitors whom he instructs.

CARE OF ILLEGITIMATE INFANTS.

The Council has an arrangement with the Smethwick Branch of the Birmingham Diocesan Council for Moral Welfare, and makes a financial grant. The local authority and the Diocesan Council work very closely together, and the scheme provides for complete liaison. Twelve cases were dealt with during the year.

OPHTHALMIA NEONATORUM.

	1946	1947	1948	1949
Number of cases notified	16	9	10	6
Cases treated by health visitors	1	1	—	1
Number of cases treated at Eye Hospital	16	9	9	1
Cases resulting in impaired vision ...	—	—	—	—
Home visits	29	19	29	7

Notifications during the past ten years:—

1940	6	1945	8
1941	14	1946	16
1942	8	1947	9
1943	8	1948	10
1944	9	1949	6

HEALTH VISITING.

The establishment comprises a Superintendent and nineteen health visitors, who are also school nurses, but staff shortage has continued during the year and only twelve were actually employed at the end of the year, devoting to health visiting (all classes) the equivalent of the whole time services of seven health visitors.

The student trained last year successfully passed the health visitor's examination and joined the permanent staff. Six further students were trained during the year, two in association with the Birmingham Public Health Department, two at Hull, one at Oxford, and one at the Battersea Polytechnique. Five of these have qualified and joined the permanent staff early in 1950.

The number of visits paid during the year was:—

1. To Expectant Mothers	First visits ...	218
	Total visits ...	301
2. To Children Under One Year of Age	First visits ...	1,259
	Total-visits ...	4,015
3. To Children Between One and Five	First visits ...	2,183
	Total visits ...	9,491
4. To Other Classes	First visits ...	586
	Total visits ...	1,303

The total number of visits paid by the nurses in 1938 and in each of the last five years is as follows:—

1938	18,899	1947...........	15,987
1945	21,572	1948	19,017
1946	19,355	1949	15,616

DAY NURSERIES.

The number of approved places at Brasshouse Lane Nursery was reduced from 60 to 45 in August, 1949, in consequence of two of the rooms occupied by the nursery being returned to the Education Committee for school purposes.

There was also a reduction in places at Edgbaston Road Nursery from 60 to 49 on the advice of the Ministry of Health inspector.

The proposed extension of Norman Road Nursery has not yet received final approval of the Ministry of Health.

The total attendances during the year show some decrease at 32,165, a daily average (excluding Saturday) of 126.1, compared with 34,366, an average of 135 in 1948. The number of individual children on the registers at the end of the year was 141. There is a long waiting list at each of the nurseries.

Nursery	No. of Places	Total Attendances 1948.	Average daily Attendances.	No. of Places	Total Attendances 1949.	Average daily Attendances.
Brasshouse Lane	60	13,127	52	45	10,770	42
Edgbaston Road ..	60	13,040	51	49	13,059	51
Norman Road ...	35	8,199	32	35	8,336	33

"THE HOLLIES."

This home for children, situated in Coopers Lane, combines prevention, care, and after-care. Children from one to twelve years are received, especially those who are predisposed to disease, and those convalescing after hospital treatment.

The home has thirty beds, and is staffed by a Matron, Sister and six Nurses. Those children of school age who are fit to attend school, go to the Firs Open-Air School, adjoining "The Hollies," but take their meals and sleep in the home.

Children are usually referred by the doctors at our clinics, or direct from the hospitals. Recommendations from the family doctor are also welcomed.

Details of admissions and discharges during the year 1949 are shown below:—

Condition.	In-Patients 1/1/49	Admitted		Discharged		Re-maining 31/12/49
		Under School Age	School Age	Under School Age	School Age	
Rheumatism	3	—	14	—	16	1
Chorea	—	—	7	—	7	—
Marasmus	—	2	2	2	2	—
Malnutrition	—	1	5	1	5	—
Asthma	1	—	4	—	2	3
Pre-Tuberculous	1	1	5	1	5	1
Convalescence	—	1	—	1	—	—
Others	5	1	4	1	8	1
Cases admitted on behalf of Children's Committee	1	35	3	31	—	8
Other authorities	1	—	11	—	7	5
Totals	12	41	55	37	52	19

OTHER PUBLIC HEALTH SERVICES.

Mental Health.

On the 5th July, 1948, all duties relating to mental treatment and mental deficiency, together with care and after-care of persons suffering from mental illness and defectiveness, were taken over by the Health Department. One Duly Authorised Officer was appointed and a member of the administrative staff acts as his deputy.

After-care work is undertaken in respect of male patients by the Duly Authorised Officer, and in respect of female patients by one of the Health Visitors. The number of discharges from mental hospitals during the year was 74; of these 44 accepted after-care, 13 declined after-care and 10 did not reply to our invitation. Seven returned to hospital for further treatment. During the year 284 visits were made by the department's Officers.

The following table gives details of the admission and discharges of mental patients during the year:—

Mental Hospitals.	No. of Patients 1/1/49	Admissions Certified	Admissions Voluntary	Deaths	Discharges	No. of Patients 1/1/50
St. Matthews	218	1	5	8	13	203
Winson Green	8	7	7	2	14	6
Cheddleton	10	1	—	—	1	10
Highcroft Hall	8	49	24	14	44	23
New Cross (Observation Wards)	18	—	—	—	1	17
Barnsley Hall	—	2	1	1	1	1
Stafford	1	—	—	—	—	1
Burghill, Hereford..	8	—	—	—	—	8
County and City, Hereford	3	—	—	—	—	3
West Ham, Essex .	5	—	—	—	—	5
Park Prewett, Hants.	1	—	—	—	—	1
Cambridgeshire	1	—	—	—	—	1
Newport Borough .	1	—	—	—	—	1
East Riding, Beverley	1	—	—	—	—	1
Rubery	1	—	—	—	—	1
Totals	284	60	37	25	74	282

MENTAL DEFICIENCY ACTS, 1913 to 1938.

The following is an extract from the return of Mental Defectives as on 1st January, 1950:—

	M.	F.	Total
1. Number of Ascertained Mental Defectives found to be " subject to be dealt with ":—			
(*a*) In Institutions (including cases on licence therefrom):			
Under 16 years of age	2	4	6
Aged 16 years and over	43	38	81
(*b*) Under Guardianship (including cases on licence therefrom):			
Under 16 years of age	1	—	1
Aged 16 years and over	6	9	15
(*c*) In " places of safety "	—	—	—
(*d*) Under Statutory Supervision (excluding cases on licence):			
Under 16 years of age	9	7	16
Aged 16 years and over	53	42	95
(*e*) Action not yet taken under any one of the above headings	—	—	—
TOTAL ascertained cases found to be " subject to be dealt with "	114	100	214
No. of cases included in (b) to (e) above awaiting removal to an Institution ...	2	1	3
2. Number of Mental Defectives not at present " subject to be dealt with," but over whom some form of voluntary supervision is maintained:—			
Under 16 years of age	—	—	—
Aged 16 years and over	55	46	101
TOTAL number of mental defectives (1) plus (2)	169	146	315
3. Number of Mental Defectives Receiving Training:—			
(*a*) In day-training centres:			
Under 16 years of age	—	—	—
Aged 16 years and over	—	2	2
(*b*) At home	—	—	—
TOTAL	—	2	2

PARTICULARS OF CASES REPORTED DURING THE YEAR 1949.

1. ASCERTAINMENT.

	M.	F.	Total
(*a*) Cases reported by Local Education Authorities (Section 57, Education Act, 1944):—			
(i) Under Section 57 (3)	—	1	1
(ii) Under Section 57 (5):—			
On leaving special schools ...	3	1	4
On leaving ordinary schools ...	—	—	—
(*b*) Other ascertained defectives reported during 1949 and found to be " subject to be dealt with "	—	2	2
TOTAL ascertained defectives found to be " subject to be dealt with " during the year	3	4	7
(*c*) Other reported cases ascertained during 1949 who are not at present " subject to be dealt with "	2	1	3
TOTAL number of cases reported during the year	5	5	10

2. DISPOSAL OF CASES REPORTED DURING THE YEAR:—

	M.	F.	Total
(*a*) Ascertained defectives found to be " subject to be dealt with ":			
(i) Admitted to Institutions	—	—	—
(ii) Placed under Guardianship ...	1	—	1
(iii) Taken to " places of safety " ...	—	—	—
(iv) Placed under Statutory Supervision	2	3	5
(v) Died or removed from area ...	—	1	1
(vi) Action not yet taken	—	—	—
TOTAL ascertained defectives found to be " subject to be dealt with " (to agree with the total of (1) (a) (1) (b) above) ...	3	4	7

(*b*) Cases not at present " subject to be dealt with ":

(i) Placed under Voluntary Supervision	2	1	3
(ii) Later found not to be defective ...	—	—	—
(iii) Died or removed from area ...	—	—	—
(iv) Action unnecessary	—	—	—
(v) Action not yet taken	—	—	—
TOTAL cases not at present " subject to be dealt with " (to agree with the numbers entered under (1) (c) above)	2	1	3

HOME VISITING OF MENTAL DEFECTIVES.

The number of cases under supervision is 212 and to these 1,070 visits were made during the year, 884 by the duly authorised officer and 186 by the health visitors.

AMBULANCE SERVICE.

The Council maintains a fleet of seven ambulances and two sitting case cars operated from the Borough Ambulance Station, Highway Garage, Londonderry Lane (Telephone SME 0674). A full day and night service is available to all Smethwick residents, without charge.

Particulars of the vehicles are as follows:—

Reg. No.	Make	H.P.	Type	Capacity	Year
DHA 444	Austin	24	Coachbuilt	1 stretcher	1936
CDG 55	Wolseley	25	Converted	2 stretchers	1938
DOE 165	Morris	18	Coachbuilt	1 stretcher	1938
FHA 384	Morris	26	Coachbuilt	2 stretchers	1939
HOJ 818	Austin	16	Coachbuilt	2 stretchers	1948
MHA 18	Austin	16	Coachbuilt	2 stretchers	1949
OHA 30	Daimler	27	Coachbuilt	2 stretchers	1949
BHA 290	Morris	18	Saloon	3 seats	1936
MHA 396	Austin	16	Utility	3 seats	1949

The whole-time staff, under the direction of the Medical officer of Health, comprises an Ambulance Officer, Assistant Ambulance Officer, nine drivers and attendants, three whole-time and one part-time telephonist, and necessary domestic staff.

The service is manned by the paid staff from 6.30 a.m. until 7.30 p.m. During the night and at week-ends the vehicles are manned by volunteer drivers and attendants who are members of the British Red Cross Society and the St. John Ambulance Brigade; these volunteers are most punctual and regular in their attendance, and the standard of their service is exceptionally high. Our thanks are due to them for their public-spirited work.

The table below gives details of the work of the Ambulance Service during 1948 and 1949.

Patients conveyed to or from:	1948	1949
Accident Cases	582	748
Accident Hospital, Birmingham	2,711	3,463
Children's Hospital, Birmingham	75	57
Dudley Road Hospital, Birmingham	313	1,104
General Hospital, Birmingham	1,120	1,339
Queen Elizabeth Hospital, Birmingham ...	135	200
St. Chad's Hospital, Birmingham—Illness ...	1,232	604
Maternity..	1,169	791
Hallam Hospital, West Bromwich	38	37
West Bromwich and District General Hospital...	163	183
New Cross Hospital, Wolverhampton	75	27
Holly Lane Isolation Hospital, Smethwick ...	195	336
Smethwick Orthopædic Clinic	2,488	2,794
Removals in the Borough	95	49
Other Hospitals	949	1,131
	11,340	12,863

Number of journeys	5,652	6,701
Miles travelled	70,118	81,619
Motor spirit consumed	6,675 gallons	7,132 gallons

HOME NURSING SERVICE

The Council employs three whole-time and two part-time nurses for the nursing of patients in their own homes. The service is based on the Edward Cheshire Nurses' Home in Bearwood Road. One of the senior health visitors is seconded for the supervision of the service, along with the domestic help service.

Details of the work done during the year are as follows:—

Number of patients under care on 1.1.49 ...	46
New patients attended during the year ...	599
Number recovered or transferred to hospital...	454
Number of deaths	124
Number of patients under care 31.12.49 ...	67
Visits paid by the nurses during the year ...	13,086

DOMESTIC HELP SERVICE.

It has been possible to expand considerably the service for providing help in the home during the year. At the end of the year we had six whole-time and eight part-time domestic helpers and the number employed increased to 23 by the middle of 1950.

One hundred and twelve cases were assisted, some for long periods. The conditions of patients for whom domestic help was provided are set out below:—

Confinement	29
Aged	16
Cardiac	12
Post Operative	7
Arthritis	7
Tuberculosis	6
Respiratory Diseases	6
Cerebral Hæmorrhage and Hemiplegia ...	6
Injuries	5
Carcinoma	3
Others	15
	112

CHIROPODY SERVICE.

Two fully trained chiropodists—one male and one female—are employed whole-time at the Cape Clinic. There is no charge for treatment, which is available to Smethwick residents of all ages.

The total attendances during 1949 were as follows:—

Children under 5 years of age	7
Children of school age	303
Expectant and nursing mothers	14
Other patients: Males	884
Females	4,799
Total	6,007

CONVALESCENT TREATMENT.

Convalescent treatment was provided during the year for 44 patients on the recommendation of the hospital or family doctor, as under:—

Condition of Patient	Men	Women	Children	Total
Post Operative	6	10	3	19
Nervous Disorders	1	5	—	6
Rheumatism and Arthritis	1	1	—	2
Following Respiratory Infections	2	4	1	7
Debility	1	7	1	9
Coronary Thrombosis ...	1	—	—	1
	12	27	5	44

The undermentioned homes were used, the normal period of stay being two weeks:—

Gable House, Droitwich	10 cases
"Rest Haven," Exmouth	5 ,,
St. Luke's Home, Exmouth	5 ,,
The Hermitage Uttoxeter	3 ,,
The Birmingham Hospital Saturday Fund Home:—	
Blackwell, near Bromsgrove	3 ,,
Kewstoke, Weston	2 ,,
Llandudno	2 ,,
Clevedon—"The Belmont" Home for Women	2 ,,
"The Victoria" Home for Men ...	2 ,,
"Epiphany," St. Agnes, Cornwall	1 ,,
The Foresters' Home, Clent	1 ,,
Lady Forester's Home, Llandudno	1 ,,
Lady Forester's Home, Much Wenlock ...	1 ,,
Rest Home, Porthcawl	1 ,,
Rustington Home, Littlehampton	1 ,,
Seabright House, St. Annes-on-Sea	1 ,,
Small Lane Farm, Earlswood, Warwickshire	1 ,,
St. Edith's Holiday Home, Leigh-on-Sea ...	1 ,,
Swancoe House, near Macclesfield	1 ,,
	44 ,,

LOAN OF SICK-ROOM EQUIPMENT.

In accordance with the Council's scheme under Section 28 of the National Health Service Act, 1946, sick-room equipment is available for needy cases from a store maintained at the Edward Cheshire Nurses' Home, Bearwood Road. Issues were made during the year to 259 persons, 441 articles being loaned as under:—

Air Rings	19
Bed Rests	60
Bed Tables	4
Bed Pans	80
Bed Cradles	17
Blankets	10
Breast Pumps	4
Beds, Hospital	5
Invalid Wheel Chairs	12
Douche Cans	2
Draw Sheets	12
Dunlop Rings	65
Feeding Cups	4
Macktinosh Sheeting	69 lengths
Mattresses	9
Pillows	4
Pyjamas	4 pairs
Syringes	1
Stool Commodes	7
Sputum Mugs	3
Sheets	22
Urinals	28
Total	441

WELFARE SERVICES

The administration of the Council's Schemes under Sections 21, 29 and 30 of the National Assistance Act, 1948, is generally the responsibility of the Medical Officer of Health, and the work is carried out by Officers of the Public Health Department, integrated wherever possible with their duties under the Council's proposals for the administration of services under Part III of the National Health Service Act, 1946.

RESIDENTIAL ACCOMMODATION FOR AGED AND INFIRM PERSONS.

On the " appointed day " there was no accommodation provided by the Council, there being no existing Poor Law Institutions within the Borough. Arrangements existed, however, with the County Borough of Wolverhampton for the reception of Smethwick residents in the " Poplars " and " Bromley House " to a maximum of seventy, and with the County Borough of Walsall for a small number to be received at " Beacon Lodge." These arrangements have been continued, and a number of cases have been admitted from time to time to accommodation provided by the City of Birmingham and other local Authorities.

A large house known as " Hill Crest," in Little Moor Hill, Smethwick (the generous gift of Mr. Arthur Mitchell) which had been used for some little time as a home for aged persons, was taken over with the consent of the Minister of Health for the purposes of Section 21 of the Act, and plans have been prepared for an extension to give accommodation for twelve additional residents. The present accommodation is for seventeen persons, who occupy seven double rooms and one single room, with a cottage for a married couple. A communal dining room and a large lounge are available on the ground floor, and there is a suitably equipped kitchen with Aga cooker, etc. The premises are centrally heated by a low pressure hot water system. There are residential quarters for the housekeeper and her husband, who acts as gardener-handyman. There is a large garden with spacious lawns, and a kitchen garden. The house is situated in a quiet residential district.

The Council also purchased a large house in Park Hill, Moseley, Birmingham, in September, 1949, and converted it into a home for nineteen aged persons of both sexes. Fortunately the amount of structural alteration was not large, consisting mainly of the provision of additional baths and sanitary accommodation, with additions to the cooking facilities. There is a large and very pleasant garden.

The house was in excellent condition, and the purchase of existing carpets, curtains and other fittings facilitated the furnishing and equipping of the home. There is a dining room and large lounge on the ground floor, and six bedrooms, one of which is also on the ground floor. Three of the bedrooms have two beds, two have three beds, and one (formerly the billiard room) has seven beds. On the second floor are bed-sitting-rooms for the housekeeper and assistant cook-housekeeper; other domestic staff are non-resident. The hall and dining room, and the largest bedroom, are heated by anthracite stoves, the lounge by a coal-coke fire, and the other bedrooms by electric convection heaters. The home was ready for occupation early in 1950, and at the time of writing this report fifteen aged persons were in residence. As with " Hill Crest," this home is capable of extension, but the need is not urgent.

The following table gives details of admissions to and discharges from residential accommodation during the year 1949:—

Accommodation	No. of Residents 1/1/49	Admission from Hospital	Admission from Home	Discharges to Hospital	Discharges to Home	Deaths	No. of Residents 31/12/49
Hill Crest, Smethwick ...	14	—	—	2	—	—	12
The Poplars, Wolverhampton	53	10	8	18	5	6	42
Bromley House, Wolverhampton	4	—	—	—	—	—	4
Beacon Lodge, Walsall ...	3	1	—	1	—	—	3
Birmingham Infirmary ...	1	2	2	2	1	1	1
Witton Hall, Birmingham ...	1	—	—	—	—	—	1
Quinton Hall, Birmingham ...	1	—	—	—	—	—	1
Solihull, Warwickshire ..	1	—	—	—	—	—	1
Stratford-on-Avon, Warwickshire ..	1	—	—	—	—	—	1
David Lewis Epileptic Colony, Manchester ...	1	—	—	—	—	—	1
TOTAL ...	80	13	10	23	6	7	67

TEMPORARY ACCOMMODATION.

Temporary accommodation for persons in urgent need thereof, e.g., following fire, flooding, or eviction, is available only at the "Poplars," Wolverhampton. Two cases, due to eviction, were dealt with during the year and were accommodated at the "Poplars." In these cases the Department acted in conjunction with the Children Officer who made arrangements for the reception of the children for whom accommodation was not at the moment available at Wolverhampton. In a number of cases temporary accommodation in the "Poplars" was refused, and the applicants eventually succeeded in securing accommodation in rooms. Most of the cases coming to our notice were, in fact, housing cases, whose needs could only satisfactorily be met by a family house.

CARE OF AGED PERSONS IN THEIR OWN HOMES.

The Domestic Help service and Home Nursing service are largely used by old people, for whom, of course, all the appropriate activities of the Health Department are freely available. A register of aged persons is at present being compiled.

The call for residential accommodation has not been so great as was anticipated; old people very naturally cling to their own homes as long as possible, and every effort is made to enable them to continue housekeeping as long as they are fit to do so.

The Housing Committee of the Council has made very generous provision for aged couples in ninety-eight bungalows on the Municipal Housing Estates, and further accommodation is planned. In addition there are seventeen alms-houses in Coopers Lane managed by the Harborne Parish Lands Trust.

The Sons of Rest have flourishing establishments in West Smethwick Park, Victoria Park, Lewisham Park and Lightwoods Park, within the Borough, and a "Darby and Joan Club" is held weekly at the old Vicarage of Holy Trinity Church.

REMOVAL OF PERSONS IN NEED OF CARE AND ATTENTION.

It was found necessary during the year to take action under Section 47 of the Act in two cases. The first was that of an elderly woman living in very insanitary conditions and in the last stages of chronic illness. She was removed to Western Road Infirmary, Birmingham, where after rallying for a time she relapsed and was removed to Dudley Road Hospital, where she died within two months of the making of the Order. The second case was of a man aged 85 years living alone in indescribable conditions, from which he refused to move voluntarily. An Order was obtained from the magistrates and he was removed to the " Poplars," Wolverhampton. At the expiration of the Order he elected to continue in residence.

PROTECTION OF PROPERTY.

Action was taken under Section 48 of the Act to provide temporary protection for property of persons admitted to institutions in five cases.

BURIAL OF THE DEAD.

In two cases during the year the Department took action under Section 50 of the Act for the burial of persons where no suitable arrangements had been made.

WELFARE OF OTHER HANDICAPPED CLASSES.

Apart from gathering information as to the number and the needs of other handicapped persons the Department has not taken any specific action under the provisions of the National Assistance Act. Large numbers of these persons have, of course, benefited from the appropriate services provided by the Department under Part III of the National Health Service Act and from the activities of various voluntary bodies serving the district; in particular crippled persons have continued to receive treatment and care from the Smethwick Orthopædic Clinic, a former voluntary body now taken over by the Birmingham Regional Hospital Board.

Mentally handicapped persons receive care and supervision from Officers of the Health Department, and physically handicapped children are the concern of the Maternity and Child Welfare and School Medical services of the Council.

WELFARE OF BLIND PERSONS.

The Council have made arrangements with the Birmingham Royal Institution for the Blind for promoting the welfare of blind persons for whom they are responsible. The institution maintains the Register of Blind Persons and provides all services, including home teaching, workshop employment, home employment, marketing of produce and general social welfare.

The classification of the Register as at 31st December, 1949, was as follows:—

	Males	Females	Total
Children at School—Day	2	1	3
Child of School Age in "Forelands"	1	—	1
Adults in Training—Day	2	—	2
Workshop Workers	13	4	17
Worker in Sighted Industry ...	—	1	1
Other Blind Employee	1	—	1
Home Worker	1	—	1
Unemployables at Home	36	39	75
Unemployable in Regional Board Hospital	1	2	3
Unemployables in Welfare Department Homes	2	—	2
	59	47	106

CLINICS AND TREATMENT CENTRES.

There are two comprehensive clinics, one at the " Firs," Coopers Lane, and the other at Cape Hill, in premises formerly belonging to the Birmingham General Dispensary. Both are staffed by doctors, dentists, nurses and other workers, and are open for the various services, as follows:—

Infant Welfare Centres.

The " Firs," Cooper's Lane ...	Mon. and Thurs.	2—4 p.m.
Cape Hill	Tuesday Wednesday	2—4 p.m. 9—12 noon
Bearwood: Baptist Hall, Rawlings Road	Monday	2—4 p.m.
Warley: St. Gregory's Church Hall, Wigorn Road ...	Friday	2—4 p.m.
Londonderry: Community Hall, Hurst Road	Tues. and Thurs.	2—4 p.m.
Sandwell: St. Stephen's Church Hall, Cambridge Road ...	Wednesday	2—4 p.m.
Oldbury Road: Oldbury Road Schools	Friday	2—4 p.m.

Ante-Natal Clinics.

The " Firs ":	Monday	9—12 noon.
	Tuesday	2—4 p.m.
	Wednesday	9—12 noon & 2—4 p.m.
	Friday	2—4 p.m.
Cape Hill:	Monday	2—3 p.m.
	Thursday	2—4 p.m.
	Friday	2—4 p.m.

All new patients are seen by appointment at the " Firs " on Wednesday mornings.

Post-Natal Clinics.

The " Firs ":	Friday	9—12 noon.
Cape Hill:	Monday	3—4 p.m.

Dental Inspection.

For Expectant and Nursing Mothers:—

The " Firs ": Wednesday morning.

All new Ante-Natal patients are inspected by the Dental Surgeon on their first visit to the Clinic, i.e., on Wednesday mornings.

Appointments are made for treatment.

School Clinics.

Inspection Clinic.

The " Firs ":	Tuesday	9.30—12 noon.
Cape Hill:	Wednesday	2—5 p.m.
	Friday	9.30—12 noon.

Treatment Clinic.

The " Firs ":	Monday	9.30—12 noon.
	Tuesday	2—4 p.m.
	Wednesday	9.30—12 noon.
	Thursday	9.30—12 noon.
	Friday	9.30—12 noon.
Cape Hill:	Monday	9.30—12 noon.
	Tuesday	9.30—12 noon.
	Wednesday	9.30—12 noon.
	Thursday	9.30—12 noon.

Dental Clinic.

The " Firs ":	Monday to Friday	9.30—12 noon & 2—5 p.m.

Gas Sessions Tuesday, Friday and Saturday mornings.

Casual patients seen from 9.30 to 10.30 a.m. Monday, Wednesday and Thursday.

Cape Hill:	Monday to Friday	9.30—12 noon.

Gas Sessions Wednesday and Friday mornings.

Casual patients seen from 9.30 to 10.30 a.m. on Tuesday and Thursday.

Eye Clinic.

The " Firs ":	Monday	2—4 p.m.
	Thursday	2—4 p.m.

(By appointment).

Skin Treatment and Cleansing Clinic.

Cape Hill:	Monday	9.30—12 noon.
	Tuesday	9.30—12 noon.
	Wednesday	9.30—12 noon.
	Thursday	9.30—12 noon.
	Friday	9.30—12 noon.

Ultra-Violet Light Clinic.

The " Firs ":	Tuesday	9—12 noon.
	Friday	9—12 noon.

Chest Clinic.

The " Firs ":	*Monday	6—8 p.m. (Workers only).
	Tuesday	10—12 noon (Children only).
	*Wednesday	2—4 p.m.
	Thursday	10—12 noon (Children).
	Thursday	2—4 p.m. (Treatment Clinic) (A.P. refills only).
	*Friday	2—4 p.m.

* (X-Ray Sessions).

X-Rays.

The " Firs ": Daily by appointment.

Foot Clinic.

Cape Hill: Daily by appointment.

Venereal Diseases Clinic.

General Hospital, Steelhouse Lane, Birmingham.
Daily, 10—12 noon and 5—7 p.m. (except Saturday and Sunday).
Saturday and Sunday, 10—12 noon.

REPORT OF THE CHIEF SANITARY INSPECTOR

SANITARY ADMINISTRATION.

INSPECTIONS:

Since the termination of World War II, each year has shown an increase in the volume of work carried out in the Department. This annual increase cannot, of course, continue indefinitely, but apparently the optimum point has not yet been reached. A reference to Table I will show that last year's record of 29,721 inspections has again been substantially exceeded, the total for the year under review being 31,106. In previous post war years I have had to refer to the war's legacy of accumulated arrears of sanitary defects due to neglect. Now, at last, I can say that these accumulated arrears are being overtaken.

Table II of the report gives the number of sanitary defects found and the number remedied. In 1948, for the first time since the war the number complied exceeded the number recorded by 4,571, which represented substantial progress towards catching up with arrears. The result was a reduction in the number of cases on the books at any given time, and a shortening of the time lag between the service of notices and their compliance. This year, the number complied is still in excess of the number recorded, but only by 897, indicating that equilibrium is being reached.

COMPLAINT RATE:

Most householders in this town are aware of the facilities, which are available through the health department, for securing the remedy of sanitary defects, and the number of complaints reaching the department in any given year may be regarded as a reflex of the general state of house property at that time. For the last ten years until 1948 the complaint rate steadily rose each year, but in 1949 there was a drop of 1,066 in the number of complaints received. The conclusion to be drawn from this is that the neglect of the war years is being made good.

Comparative figures over the last 21 years are set out below:—

Average for 10 pre-war years	788
1939	667
1940	788
1941	673
1942	752
1943	1,015
1944	1,422
1945	1,480
1946	1,691
1947	2,049
1948	2,382
1949	1,316

FOOD HYGIENE:

During the year under review much more attention has been given to this important subject as evidenced by the fact that visits to food premises numbered 2,199, compared with 437 in 1948 (see TABLE I).

STAFF:

The number of sanitary inspectors and assistants at work throughout the year has fluctuated between six and eight. The total man months reached 94, or an average of seven and five-sixths inspectors throughout the whole year, as compared with seven and one-sixth inspectors for the year 1948. The staff position during the year is shown below.

Deputy Chief Sanitary Inspector:

Mr. R. G. Evans	12 months.

Sanitary Inspectors:

Mr. G. J. Allen	12 months.
Mr. J. H. Morris	12 months.
Mr. E. F. Kelly	12 months.
Mr. L. G. Francis	12 months.
Mr. R. G. Marshall	12 months.
Mr. T. H. Cutler (to 24.2.49)	2 months.
Mr. J. W. M. Rivers (to 28.2.49)	2 months.
Mr. N. W. E. Cox (from 21.3.49)	9 months.
Mr. E. A. Siggers (from 1.4.49	9 months.

CONCLUSION:

I wish to place on record my appreciation of the loyal support I have received from my deputy, Mr. R. G. Evans, and every member of the staff of inspectors and clerks.

My thanks are also due to Dr. Paul for his continued friendly advice and co-operation, and to the Town Clerk and chief officers of other departments. And last, but not least, to the Chairman and members of the Health Committee, without whose support and encouragement this satisfactory record of work accomplished would not have been possible.

JOHN H. WRIGHT,

Chief Sanitary Inspector.

SANITARY INSPECTION OF THE AREA

SUMMARY OF INSPECTIONS.

The total number of visits paid to all premises for all purposes was 31,106, compared with 29,721 in the year 1948, and 23,393 in 1947. These inspections are summarised in the following table:

TABLE I.

Inspections on Complaint	4,291
Re-visits re Notices Served	17,287
Inspections re Ashes Accommodation	1,005
Re-visits re Ashes Accommodaticon	1,376
Housing Act Re-visits	83
Visits to Housing Work in Progress	55
Bakehouses	55
Overcrowding	433
Infectious Diseases	300
Markets Inspected	71
Food Inspections	259
Meat and Other Food Premises	2,199
Ice Cream Vendors	506
Food Sampling	479
Dairies and Milk Shops	431
Factories	307
Outworkers	61
Prevention of Damage by Pests Act	57
Pigsties and Stables	174
Drains Tested	138
Insect Pests and Vermin	305
Private Slaughtering	110
Visits re Smoke Abatement	213
Shops Act Inspection	2
Workplaces	2
Smoke Observations	25
Canal Boats	2
Water Sampling	1
Fertiliser and Feeding Stuffs Sampling	8
Hairdressers' Premises	1
Miscellaneous	870
	31,106

SUMMARY OF DEFECTS.

The following table gives a summary of the various defects encountered in the course of visits paid to all types of premises, together with the number of defects remedied under each heading:—

TABLE II.

	Found	Remedied
Dirty Premises	755	841
Defective Roofs, Spouting, etc. ...	1,132	1,343
Blocked Drains	347	358
Defective or Insufficient Paving ...	31	24
Defective Sinks and Waste Pipes ...	93	90
Accumulation of Offensive Matter ...	52	60
Defective Plaster of Walls and Ceilings	948	1,109
Defective Ashbins or Ashplaces ...	762	821
Defective W.C.'s	270	294
Insufficient Lighting and Ventilation ...	452	532
Overcrowding	51	40
Defective Water Fittings	229	199
Insufficient Water Supply	31	38
Insufficient W.C. Accommodation ...	8	10
Lack of Sinks	3	1
Dampness	338	333
Dangerous Buildings	37	42
Defective or Insufficient Drainage ...	58	83
Lack of Suitable Coalstore	9	7
Defective Washboilers	52	82
Defective External Brickwork and Chimneys	429	521
Defective Floors	237	290
Defective Firegrates	115	138
Defective Stairs and Handrails	42	48
Defective Woodwork of Doors, Windows, etc.	274	331
Defective Rainwater Cisterns	35	42
Rats—Surface Infestations	271	271
Rats—Sewer Infestations	1,323	1,323
Lack of Foodstore	5	2
Smoke Nuisances	4	4
Animals kept so as to be a nuisance ...	1	5
Defective Waste Water Closets	1	1
Miscellaneous	90	99
	8,485	9,382

WATER SUPPLY.

(1) The quality and quantity of the water supplied to the town by the South Staffordshire Waterworks Company have been well maintained throughout the year.

(2) Regular bacteriological and chemical analyses are made of the water, both prior to treatment and going into supply.

(3) The water is derived chiefly from deep boreholes through red sandstone and having a hardness of 16 to 17 parts per hundred thousand has no plumbo-solvent action.

(4) No cases of contamination have been reported during the year.

(5) The number of houses in the town now sharing a common water supply remains at 1.1 per cent. and the position with regard to water is set out below:—

	Houses	Population	Percentage
Internal water supply ...	20,346	69,175	95.9
Separate outdoor supply	625	2,125	3.0
Communal water supply	247	840	1.1

WORK CARRIED OUT BY THE CORPORATION IN THE OWNERS' DEFAULT.

During the year under review the Corporation has executed work at the cost of the owner, and in default of his compliance with Notices, as follows:—

(1) Cleansing or repair of blocked or defective drains and repairs to defective W.C.'s under Section 49 of the Smethwick Corporation Act, 1929	262 cases
(2) The supply of galvanised iron ashbins with covers, under Section 75 of the Public Health Act, 1936...	259 cases
(3) Abatement of nuisances in default of compliance with Orders of the Court, Section 95, Public Health Act, 1936	7 cases

HOUSING ACT, 1936—OVERCROWDING.

At the close of the year there were on the register 109 cases of overcrowding. The number of overcrowded cases abated during the year was 40, of which 10 were abated by the Corporation providing alternative accommodation for the overcrowded family.

RATS AND MICE DESTRUCTION.

The number of premises cleared of rats and mice during the year was 271, and the estimated number of rats killed was 1,542.

One full treatment and one maintenance treatment of the town's sewers were also undertaken, baits being deposited in a total of 1,323 manholes. Twenty-seven complete takes and 721 partial takes were recorded.

INSPECTION AND SUPERVISION OF FOOD.

MILK SUPPLY.

The number of samples submitted for bacteriological examination was 127. The results of the examinations are summarised in the following table:—

TABLE III.

Type of Milk	No. of Samples	Tests Applied	Satis- factory	Unsatis- factory
Pasteurised ...	43	Phosphatase	41	2
		Methylene Blue ...	42	1
Tuberculin Tested (Pasteurised)	40	Phosphatase	37	3
		Methylene Blue ...	38	2
Heat Treated ...	2	Phosphatase	2	—
		Methylene Blue ...	2	—
Sterilised ...	36	Phosphatase	31	—
		Methylene Blue ...	36	—
		Turbidity Test ...	5	—
Non-designated ...	6	Methylene Blue ...	4	2

SUMMARY.

Milk examined for keeping quality (Methylene Blue)—3.9 per cent. unsatisfactory. Milk examined for efficiency of pasteurisation (phosphatase test)—4.1 per cent. unsatisfactory.

MEAT AND OTHER FOODS.

The articles of food which it has been found necessary to condemn for diseased or unsound conditions are summarised in the table below. In all cases the food was surrendered and destroyed or was so disposed of as to prevent its use for human food.

TABLE IV.

	Tons	Cwts.	Qrs.	Lb.	Ozs.
Meat	1	—	—	9	14
Fish	—	5	—	17	15½
Fruit	4	—	—	21	14
Vegetables	—	16	—	12	9
Fats	—	9	1	24	14½
Miscellaneous ...	—	12	—	5	15
	7	3	0	9	2

All butchers' meat sold for human consumption in the town is distributed from the City Meat Market and Abattoir in Birmingham. The only slaughtering carried on in the borough is of cottagers' pigs for home consumption, particulars of which are given in Table V. A reference to this table shows that these pigs continue to be remarkably healthy, only two pigs out of 86 being affected with tuberculosis. No pigs showed any evidence of non-tubercular disease.

TABLE V.

Number of pigs killed	86
Number of pigs inspected	86
Number found diseased:—	
(a) All diseases except Tuberculosis:—	
(i) Carcases of which some part or organ was condemned	Nil
(ii) Percentage of number affected with disease other than T.B.	Nil
(b) Tuberculosis only:—	
(i) Carcases of which some part or organ was condemned	2
(ii) Percentage of number affected with Tuberculosis	2.32

During the year under review, an increasing amount of attention has been paid to the conditions under which all classes of foodstuffs are stored, prepared, handled and sold. Intensive efforts have been made to secure the highest standards of hygiene in such premises, applying the standards set forth in Section 13 of the Food and Drugs Act, 1938, as minima. The requirement which has met with greatest resistance is the one which stipulates " a sufficient supply of clean water, both hot and cold " for the use of personnel. Our efforts have been directed towards securing the interpretation of this clause as requiring the installation of an appliance for the supply of constant or instantaneous hot water. Surprisingly enough we have had very little difficulty with the smaller traders, the greatest resistance being encountered in the large multiple trading concerns. Happily most of these objectors have now capitulated to the oft repeated representations and propaganda of the Department's officers and we look forward to the time when every food premises in the town will have installed a suitable hot water appliance.

Special attention has been paid to all cafes, restaurants, snack bars, ice cream parlours, etc., and to premises where food is prepared or manufactured for sale. The problem of the food hawker has been made easier by securing their registration and the registration of their premises under Section 61 of Smethwick Corporation Act, 1948.

The greater attention given to this important matter is reflected in the increased number of visits paid.

The number of visits paid to various types of premises, the primary object of which has been the securing of clean and safe food, reached the total of 4,110.

ICE CREAM.

At the close of the year 152 premises were registered for the manufacture and/or sale of Ice Cream. This compared with 88 registrations in 1948. All these premises have been regularly visited and the provisions of both the Ice Cream (Heat Treatment) Regulations, 1947, and the Food and Drugs Act, 1938, Section 13, are being observed.

Sixty-eight samples of Ice Cream were submitted for bacteriological examination during the year.

The registered premises are as follows:—

For manufacture and sale (Hot Mix Process) ...	6
For manufacture and sale (Complete Cold Mix)...	19
For sale only	127
	152

CHEMICAL AND BACTERIOLOGICAL EXAMINATION OF FOOD.

The Borough Analysts, Messrs. Bostock, Hill and Rigby, of Birmingham, carry out chemical analyses of food, drugs, water, air, etc., and bacteriological examination of Ice Cream.

Bacteriological examination of food, including examination of milk for methylene blue reduction test, bacterial count, phosphatase test, and the presence of B. Coli, as well as the biological examination of milk for the presence of Tubercle Bacilli were undertaken at the Department of Bacteriology, The Medical School, Hospitals Centre, Birmingham.

TABLE VI.

SUMMARY OF ARTICLES OF FOOD AND DRUGS SUBMITTED TO THE PUBLIC ANALYST AND THE RESULTS OF THE ANALYSES.

Article Analysed	Total Samples	Genuine	Not Genuine
Milk	80	72	8
Herbs, Spices and Flavourings...	5	4	1
Cake Mixture, Leavening Agents, etc.	7	7	—
Sundry Drugs and Laxatives ...	16	12	4
Condiments	4	4	—
Meat and Fish Pastes	11	11	—
Sauces, Relishes, Pickles, etc. ...	11	8	3
Confectionery	5	4	1
Fats and Oils	7	6	1
Cordials, Fruit Drinks	2	2	—
Miscellaneous Vegetables... ...	2	2	—
Soups	1	1	—
Fish Cakes	4	4	—
Ginger	2	2	—
Coffee and Chicory	3	3	—
Sausages, Savouries, etc. ...	23	13	10
Farinoca	1	1	—
Rice	1	1	—
Ice Cream	61	61	—
Custard Powder	2	2	—
Semolina	1	1	—
Tea Sweeteners	1	1	—
Gelatine	1	1	—
Meat Pies	2	2	—
Barlova	1	1	—
	254	226	28

1. INSPECTIONS OF FACTORIES.

INCLUDING INSPECTIONS MADE BY SANITARY INSPECTORS.

PREMISES.	Number on Register	NUMBER OF Inspections	NUMBER OF Written notices	NUMBER OF Occupiers prosecuted
(i) Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by Local Authorities	17	28	1	—
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	184	279	28	—
(iii) Other Premises in which Section 7 is enforced by the Local Authority (excluding out-workers' premises)	—	—	—	—
TOTAL	201	307	29	—

2. CASES IN WHICH DEFECTS WERE FOUND.

PARTICULARS.	Number of cases in which defects were found.				Number of cases in which prosecutions were instituted
	Found	Remedied	Referred To H.M. Inspector	Referred By H.M. Inspector	
Want of cleanliness (S.1)	—	—	—	—	—
Overcrowding (S.2)	—	—	—	—	—
Unreasonable temperature (S.3)	—	—	—	—	—
Inadequate ventilation (S.4)	—	—	—	—	—
Ineffective drainage of floors (S.6)	—	—	—	—	—
Sanitary Conveniences (S.7):					
(a) insufficient	—	—	—	—	—
(b) unsuitable or defective	28	16	—	—	—
(c) not separate for sexes	—	—	—	—	—
Other offences against the Act (not including offences relating to Outwork)	—	—	—	—	—
TOTAL	28	16	—	—	—

APPENDIX.

Cause of Deaths at different Periods of Life in the County Borough of Smethwick, 1949.

CAUSES OF DEATH	Sex	All Ages	0—	1—	5—	15—	45—	65—
ALL CAUSES	M	492	26	7	3	37	149	270
	F	484	29	5	2	29	93	326
1. Typhoid and Paratyphoid Fevers... ...	M	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—
2. Cerebro-Spinal Fever	M	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—
3. Scarlet Fever	M	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—
4. Whooping Cough	M	—	—	—	—	—	—	—
	F	2	1	1	—	—	—	—
5. Diphtheria	M	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—
6. Tuberculosis of Respiratory System ...	M	31	—	—	—	12	16	3
	F	14	—	—	—	9	5	—
7. Other Forms of Tuberculosis	M	3	—	1	—	1	1	—
	F	2	—	1	—	1	—	—
8. Syphilitic Disease	M	1	—	—	—	—	—	1
	F	2	—	—	—	—	—	2
9. Influenza	M	10	—	—	—	—	3	7
	F	10	—	—	—	—	1	9
10. Measles	M	1	1	—	—	—	—	—
	F	—	—	—	—	—	—	—
11. Acute Poliomyelitis and Polioencephalitis	M	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—
12. Acute Infectious Encephalitis	M	—	—	—	—	—	—	—
	F	1	—	—	—	1	—	—
13. Cancer of Buccal Cavity and Œsophagus (M), Uterus (F)	M	8	—	—	—	—	1	7
	F	5	—	—	—	—	1	4
14. Cancer of Stomach and Duodenum ...	M	22	—	—	—	—	10	12
	F	13	—	—	—	—	3	10
15. Cancer of Breast	M	—	—	—	—	—	—	—
	F	15	—	—	—	4	4	7
16. Cancer of all other Sites	M	60	—	—	—	4	29	27
	F	37	—	—	—	4	13	20
17. Diabetes	M	—	—	—	—	—	—	—
	F	9	—	—	—	—	4	5
18. Intra Cranial Vascular Lesions	M	35	—	—	—	—	11	24
	F	58	—	—	—	1	16	41
19. Heart Disease	M	135	—	—	—	8	29	98
	F	154	—	—	1	1	17	135
20. Other Diseases of the Circulatory System	M	19	—	—	—	1	6	12
	F	23	—	—	—	—	6	17
21. Bronchitis	M	43	1	—	—	1	18	23
	F	29	2	—	—	—	6	21
22. Pneumonia	M	25	7	2	—	1	2	13
	F	21	4	—	—	2	1	14
23. Other Respiratory Diseases...	M	6	—	—	—	1	2	3
	F	5	—	—	—	1	1	3
24. Ulceration of the Stomach or Duodenum	M	8	—	—	—	—	3	5
	F	1	—	—	—	—	1	—
25. Diarrhœa under two years	M	3	3	—	—	—	—	—
	F	5	5	—	—	—	—	—
26. Appendicitis	M	3	—	—	—	1	1	1
	F	1	—	—	—	—	—	1
27. Other Digestive Diseases	M	6	—	—	—	—	4	2
	F	6	1	—	—	—	1	4
28. Acute and Chronic Nephritis	M	11	—	—	—	2	4	5
	F	12	—	—	—	—	3	9
29. Puerperal and Post Abortive Sepsis ...	F	—	—	—	—	—	—	—
30. Other Maternal Causes	F	—	—	—	—	—	—	—
31. Premature Birth...	M	5	5	—	—	—	—	—
	F	8	8	—	—	—	—	—
32. Congenital Malformation, Birth Injury, Infantile Disease	M	10	9	1	—	—	—	—
	F	10	7	1	—	—	1	1
33. Suicide	M	3	—	—	—	—	2	1
	F	4	—	—	—	—	2	2
34. Road Traffic Accidents	M	2	—	—	1	—	1	—
	F	—	—	—	—	—	—	—
36. Other Violent Causes	M	9	—	1	1	3	1	3
	F	6	1	—	—	—	1	4
36. All other Causes	M	33	—	2	1	2	5	23
	F	31	—	2	1	5	6	17